



**643rd Meeting of the Health Services Cost Review Commission**

**June 10, 2026**

(The Commission will begin in public session at 12:00 pm for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 pm)

**CLOSED SESSION**

**12:00 pm**

1. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

**PUBLIC MEETING**

**1:00 pm**

1. Review of Minutes from the Public and Closed Meetings on May 13, 2026

**Specific Matters**

For the purpose of public notice, here is the docket status.

**Docket Status – Cases Closed**

2689N Luminis Health Doctors Community Medical Center  
2696A Johns Hopkins Health System  
2697A Johns Hopkins Health System

1. **Docket Status – Cases Open**

2695N TidalHealth Peninsula Regional Medical Center  
2670A University of Maryland Medical Center- 2nd Extension Request  
2698A Johns Hopkins Health System  
2699A University of Maryland Medical Center  
2700A University of Maryland Medical Center

2. Final Staff Recommendation Request to Access HSCRC Confidential Data: Johns Hopkins Center for Population Health IT
3. Final Staff Recommendation Request to Access HSCRC Confidential Data: University of Maryland, Baltimore

**Subjects of General Applicability**

4. Report from the Executive Director
  - a. Policy Calendar Update

5. Final Recommendation: Update Factor - FY27
6. Final Recommendation: Health Outcomes Payment Effort
7. Final Recommendation: CRISP HIE Funding - FY27
8. Final Recommendation: Inpatient Length of Stay
9. Draft Recommendation: Global Budget Carve Out
10. Hearing and Meeting Schedule

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**As an advance notice for next month's commission meeting, the meeting originally scheduled for July 8, 2026, has been rescheduled to Wednesday, July 22, 2026.**

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**AMENDED MINUTES OF THE  
642ND MEETING OF THE  
HEALTH SERVICES COST REVIEW COMMISSION  
MAY 13, 2026**

**AMENDED LANGUAGE IS BOLDED ON PAGE 8**

Chairman Joshua Sharfstein, M.D. called the public meeting to order at 12:00 p.m. In addition to Chairman Sharfstein, also in attendance were Vice Chairman James Elliott, M.D., David Maine, M.D., Nicki McCann, J.D., Ricardo Johnson, J.D., and Farzaneh Sabi, M.D. Joining by Zoom, Jon Blum, M.P.P. Upon a motion made by Commissioner McCann and seconded by Vice Chairman Elliott, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 1:10 p.m.

**REPORT OF MAY 13, 2026, CLOSED SESSION**

Mr. William Hoff, Deputy Director, Audit and Integrity, summarized the items discussed during the May 13, 2026, Closed Session.

**ITEM I  
REVIEW OF THE MINUTES FROM APRIL 15, 2026, PUBLIC MEETING  
AND CLOSED SESSION**

Upon motion a made by Commissioner Sabi and seconded by Commissioner McCann, the Commission voted unanimously to approve the minutes of the April 15, 2026, Public Meeting and Closed Session and to unseal the Closed Session minutes.

**INFORMATION SESSION: THE HONORABLE BEN CARDIN**

Chairman Sharfstein welcomed Senator Ben Cardin to share a historical perspective on the model due to his long-standing, critical role with the Maryland model. Senator Cardin began his remarks by emphasizing that no one can afford to sit on the sidelines in today's climate. Although he is no longer serving in the United States Senate, he assured the audience that he remains deeply and actively engaged in promoting civil discourse and civic participation through his ongoing work at institutions like Towson University and Johns Hopkins.

Senator Cardin acknowledges that while many people in the room have a lengthy history with the HSCRC and Maryland's healthcare laws, his own connection to the system goes back the furthest, having been present right at its very inception. He was serving as the Vice Chairman of the Ways and Means Committee in the Maryland General Assembly when the system was originally developed. Over the subsequent decades, he had the unique privilege of watching the model evolve and succeed. He highlighted the tangible, historic success of Maryland's unique hospital reimbursement rate system. Because of the Commission's dedicated work, Maryland

**Joshua Sharfstein, MD**  
Chairman

**James N. Elliott, MD**  
Vice-Chairman

**Jonathan Blum, MPP**

**Ricardo R. Johnson**

**David N. Maine, MD**

**Nicki McCann, JD**

**Farzaneh Sabi, MD**

**Jonathan Kromm, PhD**  
Executive Director

**William Henderson**  
Director  
Medical Economics & Data Analytics

**Gerard J. Schmith**  
Director  
Revenue & Regulation Compliance

**Claudine Williams**  
Director  
Healthcare Data Management & Integrity

was able to achieve total healthcare access, eliminating the need for separate charity hospitals and establishing a lasting legacy of equitable care.

He highly praised the Commission and its leaders for their ability to buck political pressures over the years. He commends them for demonstrating true leadership by consistently prioritizing the needs of the broader community over the individual interests of their own institutions.

If he could explain the Maryland model to an outsider in a brief elevator pitch, Senator Cardin highlighted the core principle that all patients, regardless of their payer, trigger the same basic reimbursement rate for hospitals and healthcare centers. He noted that while this concept may not be perfectly pure today, standardizing these payments is crucial because it ensures financial equity across facilities, allowing them to remain located in all communities and maintain a uniform quality of care. He emphasized that uniform reimbursement removes the economic pressure for healthcare providers to bias their locations toward wealthier areas, thereby eliminating the need for separate charity hospitals.

In his concluding remarks, Senator Cardin expressed gratitude and acknowledges the critical contributions of his partners and colleagues, specifically highlighting former Senator Barbara Mikulski and various members of the congressional and state legislatures who helped maintain the state's healthcare system over the years. He admits to a sense of frustration regarding their inability to secure a permanent all-payer waiver, which he views as the hallmark of their efforts. While recognizing that the system cannot be perfectly pure under current conditions, he emphasizes the critical importance of preserving this foundational principle and voices his hope to eventually restore a system that aligns fully with the original purpose of the law.

**No action was taken on this agenda item.**

**ITEM II**  
**CLOSED CASES**

2694A          Johns Hopkins Health System

**ITEM III**  
**OPEN CASE**

2689N          Luminis Health Doctors Community Medical Center  
2695N          TidalHealth Peninsula Regional Medical Center  
2696A          Johns Hopkins Health System  
2697A          Johns Hopkins Health System

**ITEM IV**  
**FINAL RECOMMENDATION: Nurse Support Program (NSP) II COMPETITIVE GRANTS –**  
**FY 2027**

Ms. Erin Schurmann, Associate Director, Strategic Initiatives, joined by her colleagues Dr. Laura Schenk, Grant Administrator, Nurse Support Program II (NSP II), Ms. Kimberly Ford, Assistant

Grant Administrator NSPII and Ms. Alicia Ganey, Grant Specialist NSPII from the Maryland Higher Education Commission, presented *the Staff's Final Recommendation: NSP II Competitive Grants – FY2026* (see “ *Final Recommendation: NSP II Competitive Grants -FY 2027*” available on the HSCRC website).

Dr. Schenk opened her presentation by requesting approval from the Commission for the Fiscal Year (FY) 2027 NSPII Competitive Institutional Grant recommendations. She noted that following the program's renewal last year, this marks the first time the standard annual grant panel's recommendations have been brought forward for approval. Additionally, the FY 2026 Annual Report detailing grant outcomes and performance metrics, previously approved by the Commission last February, will be presented later this year.

The NSPII review panel convened and recommended advancing all received proposals, resulting in a total request of \$20.8 million to fund 39 grants. These recommendations span 18 institutions statewide and will provide resources benefiting all 30 schools of nursing in Maryland. The funding structure includes a diverse mix of planning, implementation, continuation, and resource grants, with project durations ranging from one to five years.

The primary objective of these grants is to support critical NSPII priority initiatives that directly strengthen the Maryland nursing workforce. Specifically, the funded projects aim to expand pre-licensure RN enrollment capacity, support degree advancement, and enhance practice and education partnerships between schools and hospitals. Furthermore, the initiatives focus on growing teaching capacity, building a future faculty pipeline, advancing community and population health, and improving statewide faculty recruitment and retention.

Ms. Schurmann presented the staff's Final Recommendation for NSPII Competitive Grants for FY 2027:

1. Approval of grant funding for 30 proposals totaling \$20.8 million.
2. Proposals address the seven (7) priority areas of the NSP II:
  - Pre-licensure enrollment growth
  - Degree advancement (BSN, MSN, DNP, PhD)
  - Practice-education partnerships
  - Statewide teaching capacity expansion
  - Cohen Scholars for future educators
  - Community/ Population Health
  - Recruitment and retention of nurse faculty

### **Commissioner Discussion:**

Commissioner McCann raised a question regarding the long-term sustainability and financial integration of the Nurse Support Program II (NSPII) as the state plans for the future under AHEAD. Specifically, she asked whether there are ongoing discussions or concerns about building programs like the NSPII and CRISP into the baseline budget when Medicare assumes global budgets. She sought clarity on whether the Commission is confident that Medicare will accept these inclusions, or if alternative planning is required to ensure the future sustainability of these initiatives. Dr. Kromm confirmed that the funding is already included in the baseline budget. He reassured Commissioner McCann that there is nothing in place that would strip it out and expressed full confidence regarding its integration and long-term sustainability.

Vice Chairman Elliott asked for a status update regarding the overall success of the Cohen Scholars program. Dr. Schenk highlighted the Cohen Scholars program as a highly successful initiative that provides full tuition and fees for nurses pursuing advanced degrees to become educators, in exchange for a commitment to teach at a Maryland nursing school upon graduation. The program is actively growing; it expanded to Morgan State University last year and is expanding to Bowie State University this year, to a total of seven (7) participating institutions. Based on data from the last five years, Dr. Schenk noted that the program effectively retains educators within the state to help produce more nurses, boasting a current service obligation fulfillment success rate of approximately 70 percent.

Dr. Schenk also confirmed that all applicants who applied for the NSPII grant program did receive funding.

Chairman Sharfstein requested a motion to adopt the staff's Final Recommendation. Commissioner Maine moved to approve the Staff's Recommendation, seconded by Vice Chairman Elliott. **The motion passed unanimously in favor of the staff's Final Recommendation.**

### **ITEM V**

#### **FINAL RECOMMENDATION: CARE TRANSFORMATION INITIATIVES CHANGES**

Dr. Jon Kromm, Executive Director presented the *Staff's Final Recommendation: Care Transformation Initiatives Changes* (see "Final Recommendation: Care Transformation Initiatives Changes" available on the HSCRC website).

Dr. Kromm opened the presentation by reviewing the Care Transformation Initiative (CTI) program's end-of-year savings analysis, which raised significant concerns regarding unexpected financial volatility. The Commission's original stated intent for the program was to incentivize hospital efficiency while limiting volatility through a 2.5 percent stop-loss provision. However, because the program was designed as budget-neutral without a hard cap on gains and losses, the year 2025 performance saw a massive unforeseeable and unintended shift of over \$160 million between hospitals, revealing structural vulnerabilities in the system's functionality.

These structural vulnerabilities revealed the volatile nature of a zero-sum design lacking hard caps, and the fact that hospitals were permitted to define large patient populations even if specific interventions did not directly reach every patient. Historical context led to these hospital programs receiving only limited regulatory review. He noted that while the CTI program is already scheduled to sunset in June 2026 as Maryland transitions to the AHEAD model, any future efforts must incorporate these lessons by avoiding zero-sum structures, establishing clear risk budgets, defining specific interventions, and implementing enhanced review steps to ensure baseline reasonableness.

In response to these issues, the Commission received 15 letters of comment representing a wide spectrum of opinions. Stakeholders favoring the cancellation of the program argued that the current financial outcomes did not reflect the original policy intent, while those opposing retrospective changes expressed concern that modifications would undermine systemic confidence, reliance, and predictability. Commenters offered various solutions, such as deduplicating beneficiaries, eliminating specific inconsistent community-based care CTIs, correcting flawed scoring methodologies, and hardening the 2.5 percent stop-loss cap while eliminating the revenue-neutrality requirement.

Dr. Kromm presented the staff's Final Recommendation for the Care Transformation Initiatives Changes as follows:

- Revise the stop loss for the FY 2025 performance year (FY 2027 pay out) to redistribute amounts above the 2.5 percent cap among hospitals with positive savings, in proportion to those positive savings rather than to all hospitals in proportion to their Medicare spending.
- Eliminate the program for FY 2026 performance year (FY 2028 payout)

### **Public Testimonies:**

**Mr. Barry Rosen, Esq., Gordon Feinblatt**, speaking on behalf of LifeBridge Health, opened by highlighting that the HSCRC staff has openly acknowledged that the FY 2025 CTI results were unintended, unexpected, and unreasonable. He believed that the program's zero-sum design lacked hard caps and budget boundaries, resulting in massive, volatile financial swings. This volatility was primarily driven by "geographic CTIs," which allowed certain hospitals to secure massive bonuses simply by selecting populations with younger Medicare demographics, completely detached from actual hospital interventions. Because multiple hospitals claimed the same overlapping populations with minimal regulatory review, Mr. Rosen argued the current system fails the Commission's explicit legal mandate to set reasonable rates.

Framing the programmatic framework as a contract between the Commission and individual hospitals, he asserted that the arrangement constitutes an "illegal contract" because the Commission exceeded its statutory authority by producing arbitrary rates. Drawing from Maryland's pattern jury instructions for illegal contracts involving no fraud, he explained that a court's remedy is to leave the parties exactly where it finds them. According to Mr. Rosen,

based on this, LifeBridge proposes that the Commission completely halt all further collections and payouts for the performance years in question, effectively freezing the system so that no hospital is penalized or rewarded further under the flawed methodology.

While Mr. Rosen expressed gratitude to the staff for their updated recommendation noting that it successfully improves the situation and might earn judicial deference, he urged the Commission to consider even safer modifications. Specifically, he suggested lowering the arbitrary 2.5 percent stop-loss threshold to 1 percent or 2 percent and spreading the adjustments across all hospitals as was done in 2024, rather than just the winners. He stressed the critical need for immediate data certainty, pointing out that the reported financial figures shifted by \$20 million between April and May due to data runoff. He concluded by asking the Commission to clearly define and lock in the final dataset to eliminate ongoing financial unpredictability for the affected health systems.

Commissioner Blum sought clarity on whether the core issue lies within the specific design flaws of this particular program or if the overarching goals of the initiative themselves are flawed. Mr. Rosen clarified his position that the core issue lies entirely within the structural implementation of the program, rather than its intended goals. He explained that while the objective to lower Medicare spending by delivering the right care at the right time was valid, the actual execution allowed hospitals to benefit through not just luck but demographic selection, such as intentionally choosing favorable zip codes rather than through targeted interventions. He noted that the program's methodology was fundamentally flawed because it rewarded incremental improvement while failing to account for institutions that had already achieved high levels of performance attainment.

Commissioner Maine asked for clarification on the specific mechanics of the proposal to leave them as they are. Specifically, he inquired whether this means the FY 2025 results should be thrown out entirely, causing all hospital's rewards and penalties to completely go away. Mr. Rosen confirmed that his proposal means completely eliminating all FY 2025 rewards and penalties, ensuring no hospital receives extra Medicare funds or has Medicare money taken away. He argued that this exact approach, which the staff is already recommending for the following year, should instead be applied immediately to the performance year slated to take effect this July.

Commissioner Sabi asked Mr. Rosen to describe some of the specific CTIs that LifeBridge Health was actively involved with during the performance period. She noted that according to the comment letters, all participating hospitals invested heavily in these programs regardless of whether they ultimately emerged as financial winners or losers, suggesting that the underlying methodology simply failed to properly credit the actual work being done. Mr. Krajewski stated he did not have an answer to this question; he would have someone else get back with an answer.

Commissioner Johnson requested a legal and policy perspective on the implications that freezing the program would have on the hospitals currently categorized as winners. He pointed

out that these institutions followed the approved policy guidelines and invested resources into their programs based on the rules in place. He noted that if these winning hospitals were to suddenly receive nothing, they wondered whether they would have a strong, competing legal argument of their own against the Commission. Mr. Rosen responded that because the policy allowed certain hospitals to secure massive financial rewards simply by claiming large populations without proving their interventions actually impacted those patients, the outcome was akin to a random wheel of fortune that exceeded the Commission's authority. He argued that under the law, an entity is not legally entitled to funds generated by a flawed policy that exceeds statutory bounds, meaning competing legal claims from winners would not hold up. He noted that because the overall system still successfully reduced the total cost of care, all hospitals already benefited collectively, making it entirely appropriate to eliminate individual rewards and penalties to leave everyone on equal footing.

**Dr. Jack Flowers, Chief Medical Officer for Greater Baltimore Medical Center (GBMC)**, requested that the Commission carefully consider GBMC's perspective before making any retrospective changes to a program that was intentionally designed to be forward-looking. He emphasized that GBMC has participated in the CTI program in good faith since its inception, making substantial upfront investments aligned with the program's goals. Notably, the health system chose to increase its investment in primary and elder medical care by over 13 percent providing \$37.5 million in subsidies to sustain longitudinal care access even while enduring more than \$100 million in system-wide operating losses.

To deliver on these CTI commitments, Dr. Flowers said that GBMC built a robust, multidisciplinary primary care support model that integrated registered nurse care managers, care coordinators, pharmacy support, and system-wide psychiatric specialists across all of its practices. He highlighted that these were tangible, real-world investments that successfully generated positive results, yielding approximately \$8.2 million in savings within the CTI program over three years. However, he pointed out that he believed there was a structural flaw in the system's execution, revealing that due to the statewide offset mechanics, GBMC ultimately suffered a net financial loss of more than \$5.3 million during that same period despite achieving its savings goals.

**Dr. Robin Motter-Mast, Medical Director of Care Transformation at GBMC**, stated that despite acting in good faith and achieving measurable savings, GBMC failed to consistently realize a positive financial return on its investments until the current performance year. She defended GBMC's approach by stating that it carefully selected zip codes within its primary and secondary service areas where it has the infrastructure to deliver consistent longitudinal care. This selection, Dr. Motter-Mast claimed, reflected genuine, established relationships with patients rather than an opportunistic effort to optimize demographic attribution.

Dr. Motter-Mast emphasized that GBMC's success extends far beyond geographic data. Even if geographic CTIs were entirely excluded from the calculations, she stated that the health system generated approximately \$7.1 million in non-geographic CTI savings during the current program year across 10 additional initiatives. She noted that GBMC is already showing significant

savings for the upcoming 2026 program year both with and without the geographic components, demonstrating that their results are the product of broad, sustained care transformation performance rather than a single attribution strategy.

Stressing that programs like the CTI depend heavily on institutional trust, Dr. Motter-Mast argued that upfront investments made under defined regulations should be honored under those exact same rules. While urging the Commission to apply any future policy changes prospectively, she requested that if retrospective loss mitigation is deemed absolutely necessary, the staff evaluate CMS-compliant alternatives. She suggested options such as a statewide pro-rata adjustment, a smoothing mechanism, a targeted hardship approach, or an alternative funding source so that the financial burden does not fall solely on the hospitals that performed well.

Commissioner McCann inquired about the number or total amount of CTI losses experienced by the hospital in the years prior to fiscal year 2025. Dr. Motter-Mast clarified that despite GBMC generating over \$8 million in savings, the hospital ultimately had to pay out a net loss of more than \$5 million due to the system's statewide offset mechanics.

Commissioner Johnson asked if GBMC believes that the current financial results are disproportional and unreasonable, or if they view the data as legitimate numbers. He pointed out that both the staff and he, as a Commissioner, share the perspective that the resulting numbers appear to be unreasonable. Dr. Flowers responded that from GBMC's perspective as historical losers in the program, they do not view the current positive results as disproportional or unreasonable. He strongly rejected the characterization that their success was akin to winning a random wheel of fortune, explaining that he and Dr. Motter-Mast very thoughtfully and purposefully selected zip codes based on where their practices and resources were actually located. He noted that because these results stem from genuine, strategic planning across all of their participating initiatives, the numbers are legitimate rather than unreasonable.

Commissioner Maine acknowledged and appreciated GBMC's investments in primary care and care transformation within their primary and secondary service areas. However, he pointed out that because many other hospitals also operate within those exact same geographical boundaries, the methodology inherently allows for overlapping and duplicate patient attribution. He asked Dr. Motter-Mast whether or not GBMC agrees that this structural duplicity exists within the current system's design. Dr. Motter-Mast responded that the system was operating exactly as it was originally intended to run. She stated that the framework was fully designed with the expectation that there would be overlapping patient duplication among different hospital systems. **Commissioner Maine noted that GBMC's MPA revenue was \$125 million. He then inquired whether GBMC's care transformation initiatives saved \$75 million. Dr. Flowers responded that he was doubtful about the figure but asserted that GBMC did not make the rules.**

Commissioner Blum asked Dr. Motter-Mast for her thoughts and strategic advice on how the Commission should design and strengthen such programs moving forward. He noted that while

having a robust primary care base is critical for proper patient attribution, it seems to remain highly challenging to effectively manage populations when patients frequently cross between different healthcare systems. He asked for their viewpoint on how the Commission can better align specific population interventions with the targeted patient groups to make future iterations of the program more effective. Dr. Motter-Mast responded by emphasizing that the key to stronger programs moving forward lies in anchoring attribution to a patient's established primary care provider or medical home, rather than relying on broad geographic zip codes. She pointed out that while geographic models often inadvertently capture transient populations such as young, healthy individuals who move frequently and skew the data, true sustainable care transformation happens when interventions target established, longitudinal patient relationships. To prevent multiple systems from claiming the same individuals, she recommended utilizing a tiered attribution methodology that prioritizes a patient's actual primary care footprint first, followed by specialized programs like oncology or cardiology, and only using geography as a final, lower-priority fallback.

### **Commissioner Deliberation:**

The Commissioners began their deliberation by discussing the significant \$20 million data discrepancy in the CTI results. Staff clarified that current figures are preliminary and subject to shifts from standard, year-end completion factor work, with final reporting expected next month. Beyond data volatility, the Commission highlighted deep structural flaws in the program's original methodology, specifically noting that some hospitals simply learned to replicate and optimize the formula for financial gain. While a truly fair remedy would involve reversing all historical program payments, the body acknowledged this is entirely unfeasible, forcing them to balance systemic equity with practical reality.

The fundamental assumptions that justified the initial CTI policy have broken down against current fiscal realities. While the program originally caused stable revenue impacts of only 2.8 percent to 4.3 percent of Medicare Performance Adjustment (MPA) revenue, that figure has ballooned five-fold to 16.4 percent, distorting hospital performance measurements rather than accurately tracking them. Because the current dataset is viewed as unreliable, unreasonable, and inequitable, some commissioners strongly argued that the Commission has a responsibility to curb system volatility, suggesting that reducing the financial adjustments entirely to zero percent rather than the proposed 2.5 percent cap was a highly justifiable alternative.

Drawing on historical federal CMS models, the discussion shifted to whether it would be precedent-setting to change rules retrospectively. Since participating hospitals perhaps did not act fraudulently but merely optimized their operations within the program's design, some Commissioners discussed whether retroactive penalties risk destroying industry trust and discouraging future participation. However, because this state-level model is uniquely zero-sum, other Commissioners argued that a retrospective correction is justified.

Commissioner Maine requested to introduce a separate proposal regarding the post-2025 CTI framework before a final vote on the staff recommendation was called, arguing that the future policy provides necessary context for current decisions.

Chairman Sharfstein agreed to let Commissioner Maine proceed with the proposal overview but firmly maintained that he would ultimately call for a completely isolated vote on the current CTI results. He emphasized that keeping the vote clean of external factors was necessary before the Commission could transition into the next phase of the conversation.

Commissioner Maine presented a forward-looking strategy for the post-CTI framework, emphasizing that the program's flawed methodology should not overshadow the industry's dedication. He stated that it is inappropriate to conclude that hospitals facing negative CTI results failed to implement effective care transformation, noting that nearly every hospital invested heavily and performed commendable work in good faith. Under this premise, he argued that hospitals should not be financially penalized by the broader methodological distortions inherent in the current model.

To rectify these inequities, Commissioner Maine proposed that the Commission return the statewide offset amounts collected from penalized hospitals and reinvest those funds directly into the upcoming Health Outcomes and Patient Experience (HOPE) initiative. He requested that Commission staff integrate these recovered funds into the Rate Year 2027 framework and the subsequent month's HOPE proposal. This mechanism aims to hold good-faith participants harmless while keeping the capital within the healthcare system to support the sustainability of the state's care model.

The proposed reinvestment strategy relies on three strict structural principles to guide how the returned funds are allocated within the global budgets. First, 30 percent of the money would be immediately available to hospitals for planning, infrastructure, and the maintenance of ongoing, successful care transformation initiatives, as well as general HOPE readiness. The remaining 70 percent would be strictly reserved as upfront funding to support qualified HOPE initiatives over the next two years, ensuring a smooth transition into the next phase of innovation.

The Commissioners actively explored a compromise that would honor payouts for successful hospitals without financially penalizing underperforming ones. A key question was raised regarding the exact mechanism and total dollar impact if the Commission rewarded winners at the capped 2.5 percent rate while ensuring losers paid nothing. Some Commissioners noted that moving away from the program's inherent revenue neutrality might shift the financial burden onto commercial and Medicaid consumers. However, other Commissioners argued that these initiatives undeniably brought broad, valuable healthcare benefits to the people of Maryland.

Multiple Commissioners argued that their stance on the 2.5 percent cap was heavily dependent on what mitigation policies would follow, warning that a vote on the current CTI adjustments would inherently dictate the trajectory of future funding. Commissioners expressed a strong aversion to downside penalties for hospitals, stating that the sheer scale of the model's volatility this year, where revenue impacts jumped from a stable 3 percent range in prior years to an

astronomical 16.4 percent, proved that a unique, isolated intervention was required to prevent unfair financial harm.

Despite the pushback, Chairman Sharfstein expressed his desire to keep the current CTI decision entirely separate from future policy frameworks or subsequent mitigation proposals. He maintained that throwing external variables into the mix would make the process harder rather than easier and reassured the body that voting on the staff recommendation would not compromise their ability to shape separate, intelligent policies next month. While some members attempted to simplify the deadlock by suggesting an isolated vote just to officially discontinue the program for the 2026 performance year, Chairman Sharfstein asked that the Commission first vote on the staff recommendation in its entirety which couples the 2026 discontinuation with the revenue-neutral 2.5 percent cap before considering any alternative paths forward.

### **Convening of Executive Session:**

Chairman Sharfstein requested a motion and a second to temporarily halt the public deliberation and steer the Commission back into a closed executive session under the authority provided by the General Provisions Article §3-305 for the purpose of receiving legal advice from the Commission's legal counsel regarding the questions raised by the Commissioners before any official vote could take place. Commissioner Johnson made the motion to move into closed executive session, seconded by Commissioner McCann. **The motion passed unanimously in favor of moving into closed executive session at 2:30p.m.**

### **Reconvening of Public Session:**

The Public Meeting was reconvened at 2:40 p.m. Chairman Sharfstein asked for a motion to officially reopen the public meeting following the conclusion of the closed executive session. Vice Chairman Elliott made the motion to reopen, seconded by Commissioner Blum. **The motion passed unanimously in favor to reconvene the public session.**

### **Vote on Staff's Recommendation:**

Chairman Sharfstein officially recalled the Commission to the central issue of the proposed CTI changes. He then requested a formal motion to vote on the staff recommendation. Vice Chairman Elliott moved to approve the Staff's Recommendation, seconded by Commissioner Blum.

- **In favor:** Vice Chairman Elliott and Commissioner Blum.
- **Opposed:** Commissioners Johnson, Maine, McCann, and Sabi.

**The staff's Recommendation failed.**

Chairman Sharfstein asked if there was an alternative recommendation. Commissioner Johnson recommended implementing a revenue-neutral adjustment of zero percent for the performance year 2025, which would effectively eliminate any movement of dollars between hospitals. Under this proposal, the cap would be adjusted to zero, resulting in no financial winners or losers within the CTI program for the year.

Commissioner Sabi requested clarification on whether the Commission would have a future opportunity to formally acknowledge and reward the significant investments and successful care transformation work completed by hospitals. Emphasizing that valuable work had been done, she advocated for finding a mechanism to learn from these initiatives and recognize the financial and operational commitments hospitals made to these programs. Chairman Sharfstein clarified that any subsequent discussions or alternative ideas regarding hospital rewards would remain entirely separate from the current vote. He stated that those considerations would not be integrated into or play a part in the immediate decision on the CTI program.

**Vote on Alternative Recommendation:**

Chairman Sharfstein requested a motion to adopt Commissioner Johnson's alternative recommendation. Commissioner Maine moved to approve the recommendation, seconded by Commissioner McCann.

- **In favor:** Commissioners Johnson, Maine, McCann, and Sabi.
- **Opposed:** Chairman Sharfstein, Vice Chairman Elliott, and Commissioner Blum.

**The motion passed in favor of Commissioner Johnson's Recommendation.**

**ITEM VI**  
**OPEN CASES – 2689N LUMINIS HEALTH DOCTORS COMMUNITY MEDICAL CENTER**  
**(LHDC)**

*Vice Chairman Elliott recused himself.*

Mr. Bob Gallion, Associate Director, Revenue and Regulation Compliance and Mr. Anthony Martell, Associate Director, Hospital Rate Regulations & Financial Review presented the *Staff's Recommendation on Luminis Health Doctors Community Medical Center (LHDC)*. (see "Open Cases-2689N Luminis Health Doctors Community Medical Center" available on the HSCRC website).

Mr. Gallion presented a partial rate application filed in January by Luminis Health Doctors Community Medical Center. Located on a 40-acre campus in Lanham, Prince George's County, the 200-bed hospital requested an increase to its Global Budget Revenue (GBR) to cover incremental capital expenses for a new four-story facility. The purpose of this capital project is to introduce a new obstetric service to the community, with the hospital requesting a GBR increase of \$4.4 million pre-markup, which equates to approximately \$4.8 million after accounting for the standard markup.

Mr. Gallion provided historical context on the project, noting that it stemmed from a Certificate of Need (CON) originally filed in April 2023 for a \$299 million expansion that included over 302,000 square feet of renovations. Following a subsequent modification request, the hospital successfully reduced the project's scope and budget down to \$211 million while still achieving all its clinical goals. The optimized project retained the new four-story building but eliminated two-thirds of the originally planned renovations.

Mr. Martell detailed the step-by-step application of the 2019 capital policy model to calculate the hospital's Global Budget Revenue (GBR) award. He explained that the revised \$210.8 million project budget represents 64.8 percent of the hospital's permanent revenue base, easily surpassing the 25 percent threshold required to qualify for funding. Staff determined the maximum potential funding by calculating interest and depreciation costs covering 100 percent of depreciation and 70 percent of interest, which yielded an initial maximum award of \$10.7 million. The maximum award is adjusted for efficiency scaling and hospital markup, and the final award is just over \$6 million.

Mr. Gallion presented the staff's Recommendation for LHDC as follows:

1. That LHDC be awarded a permanent increment to its GBR for capital expense related to this approved project of \$5,460,721 (before the measurement of markup), or \$6,058,798 (as measured inclusive of markup).
2. Funding for this award will follow project completion and commencement of full operations.

Chairman Sharfstein requested a motion to adopt the staff's Recommendation. Commissioner Sabi moved to approve the Staff's Recommendation, seconded by Commissioner McCann. **The motion passed unanimously in favor of the staff's Final Recommendation.**

**ITEM VII**  
**CONFIDENTIAL DATA REQUEST: MARYLAND DEPARTMENT OF HEALTH,  
DEVELOPMENTAL DISABILITIES ADMINISTRATION AND LIBERTY HEALTHCARE**

Ms. Hannah Thurner, Analyst I, Healthcare Data Management and Integrity, presented the *staff's Final Recommendation: Confidential Data Request: Maryland Department of Health, Developmental Disabilities Administration and Liberty Healthcare* (see "Confidential Data Request: Maryland Department of Health, Developmental Disabilities Administration and Liberty Healthcare" available on the HSCRC website).

Ms. Thurner presented a confidential data request from the Maryland Department of Health (MDH) Developmental Disabilities Administration (DDA). The DDA is seeking access to statewide confidential inpatient and outpatient hospital discharge data sets (Data) collected by the HSCRC. In partnership with Liberty Healthcare Corporation, the DDA plans to use this Data to conduct quarterly Medicaid data correlation audit reviews. The primary objective of these audits is to verify whether serious medical incidents, specifically emergency room visits, and

unplanned hospitalizations were fully, accurately, and promptly reported through the state's incident reporting system in compliance with DDA policy.

If approved, the Data will allow the DDA to analyze population characteristics, verify hospitalizations, evaluate cost patterns, and accurately correlate Medicaid claim data with existing incident reports to support ongoing quality improvement and accountability. The request has received approval from the MDH Strategic Data Initiative (SDI) on April 10, 2026. Furthermore, the HSCRC Confidential Data Review Committee has reviewed the proposal and recommends its approval, noting that the request is limited to the minimum necessary confidential data for subjects meeting the project's precise criteria.

The recommendation for approval comes with strict data governance conditions to ensure patient privacy. The DDA is prohibited from using the Data to identify individual patients and must file annual progress reports detailing any changes to the project's design, duration, or data handling procedures. Additionally, a copy of the final report must be submitted to the HSCRC for review prior to any public release. The Data will be retained until the project's completion in 2027, at which point it must either be destroyed with a certification of destruction submitted to the HSCRC or the agreement must be formally renewed.

Ms. Thurner presented the staff's Final Recommendation for the Confidential Data Request for Maryland Department of Health, Developmental Disabilities Administration and Liberty Health as follows:

1. That the request by the Maryland Department of Health Developmental Disabilities Administration be approved for the FY 2025 Data.
2. That this access will include limited confidential information for subjects meeting the criteria for the research.

Chairman Sharfstein requested a motion to adopt the Staff's Recommendation. Commissioner Sabi moved to approve the Staff's Recommendation, seconded by Commissioner McCann. **The motion passed unanimously in favor of the Staff's Recommendation.**

**ITEM VIII**  
**FINAL RECOMMENDATION: ADVENTIST HEALTHCARE GERMANTOWN EMERGENCY ROOM CLOSURE**

Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics presented the staff's *Final Recommendation: Adventist Healthcare Germantown Emergency Room Closure* (see "*Final Recommendation: Adventist Healthcare Germantown Emergency Room Closure*" available on the HSCRC website).

Mr. Henderson presented the staff's Final Recommendation on the closure of the Germantown Emergency Center (GEC), scheduled for June 30, 2026. This follows a request submitted by

Adventist Healthcare in February 2026 to relocate emergency care access and move global revenue from the GEC to Shady Grove Medical Center (SGAMC), located 15 minutes away. Since the proposal was first discussed two months prior, Adventist completed several follow-up actions, including holding a public informational session on April 14, 2026, to solicit community input. Additionally, the Montgomery County Department of Health and Human Services (MCDHHS) provided a letter of support favoring the reinvestment of the associated funds into the community.

Financially, the GEC operates on a global budget of approximately \$19.5 million. The portion of the budget related to shifted services will be divided between Shady Grove Medical Center and Holy Cross Germantown. While the initial model illustrated an 85/15 split, the two institutions have since renegotiated a final split of 65/35, a refinement that was anticipated by the Commission. The closure will generate gross savings, and consistent with past policies, SGAMC is proposed to retain 50 percent (\$4.75 million) of these savings. The remaining 50 percent will be split, with \$2 million directed to the Montgomery County Department of Health for community initiatives and the rest accruing back to payers.

To ensure accountability, the recommendation establishes strict reporting requirements for both Adventist and Montgomery County. Adventist will submit two reports one six months after the first year and another six months after the third-year detailing community emergency room outcomes and how the retained savings were utilized. Montgomery County will provide periodic reporting on its \$2 million funding allocation after years one and two, and subsequently in years four and seven. Notably, a change to the original plan stipulates that instead of the funding automatically expiring at 10 years, the Commission will use the Year 7 report to vote on whether to continue the county's investment beyond the 10-year mark.

Mr. Henderson presented the staff's Final Recommendation as follows:

1. For FY 2027, the global budget of GEC will be eliminated, and \$15.25 M of permanent revenue will be transferred to SGMC.
  - a. \$8.5 M is the prospective market shift estimate which is subject to final review with HCG and retrospective adjustment under market shift methodology as described in Appendix A of the recommendation.
  - b. \$2.0 M annually, for at least 10 years, will be directed to Montgomery County for investment in the health needs of the community and the historic users of GEC under terms agreeable to all parties.
  - c. \$4.75 M will be retained by SGMC for investments at Adventist's discretion to address other health needs of the community, such as the expansion of access to other hospital services.
2. For FY 2027, the global budget of HCG will be increased by \$1.5 M. This is the prospective market shift estimate and is subject to final review with HCG and retrospective adjustment under market shift methodology as described in Appendix A.

### **Public Testimonies:**

**Ms. Katie Eckert, SVP, Strategic Operations, Adventist Healthcare,** noted that a public hearing had been conducted, and both the transcript and presentation slides from that event were included in the Commissioner's materials. She clarified that the overarching goal of the proposal is emergency access optimization. By relocating emergency access to Holy Cross Germantown (two miles away) and Shady Grove Medical Center (nine miles away) utilizing the 65/35 funding split previously detailed by Mr. Henderson, the project aims to provide more efficient care while actively working to reduce the community's overall reliance on emergency department (ED) visits.

A key component of this strategy involves a two-part solution for reinvesting savings into the community. Ms. Eckert highlighted a \$2 million partnership with the county and local EMS, led by Dr. Ashford and her team, which will focus on initiatives specifically designed to decrease unnecessary ED utilization. She explained that transferring the fixed-cost portion of the closed Germantown facility over to Shady Grove Medical Center will be entirely cost-neutral to the health system, adding no new expenses while unlocking capacity to address latent demand for medically necessary care.

This transferred capacity will also directly support independent community providers in Montgomery County who are currently facing barriers to access for time-sensitive, medically necessary surgical care. Ms. Eckert emphasized that this demand is primarily concentrated among the county's growing aging population, particularly within specialized fields such as oncology. The transition is designed to alleviate existing provider waitlists and ensure that vulnerable, older patients receive timely surgical interventions.

**Dr. Nina Ashford, Chief, Public Health Services, Montgomery County,** thanked the Commission and reported on two months of intense engagement with Montgomery County elected officials, community members, and safety-net partners regarding the \$2 million investment. Briefings with the county executive, chief administrative officer, Representative April McLean Delaney, and federal legislative staffs yielded strong enthusiasm and support. Local partners, including the Montgomery Cares Advisory Board, the Commission on Health, and the Health Center Leadership Coalition, emphasized the vital role the GEC has played as the primary after-hours resource for the county's most vulnerable, uninsured, and uninsurable residents. Because Montgomery Cares is not health insurance, these safety-net populations rely heavily on the emergency department to receive charity care and avoid unaffordable urgent care bills.

In response, the health department developed a four-part conceptual model designed to address community health through a systems-level approach, ensuring that 87 percent of the funding goes directly to patient care rather than infrastructure:

1. The first component allocates roughly \$200,000 to expand primary care capacity at existing Germantown and Gaithersburg clinics, allowing for enhanced night and weekend hours alongside increased same-day and next-day appointment availability.

2. The second component dedicates approximately \$470,000 to an after-hours nurse triage line contracted through an existing vendor with multilingual access and funds three community health workers to navigate patients from the ED back into their primary care medical homes.
3. The largest portion of the investment, totaling \$1 million, will fund expanded access to urgent care by contracting with an existing provider to offer discounted services to Montgomery Cares clients. Patients will contribute a \$35 copay, aligning with their standard clinic fees, which provides an alternative, lower-cost setting for low-acuity medical needs and effectively redirects them away from the emergency department.
4. Additionally, \$200,000 is earmarked for 911 innovations in partnership with the county's EMS chief, aiming to integrate new strategies within the 911 dispatch system to relieve broader systemic pressures. The remaining \$130,000 covers administrative costs, including data tracking, KPI measuring, and evaluation.

To maintain transparency and ensure these funds supplement rather than replace existing county investments, Dr. Ashford announced that the money will not flow directly to the county government. Instead, Adventist will contract with the Primary Care Coalition (PCC), the entity that already administers Montgomery Cares, to manage program implementation and claims adjudication. Success will be rigorously measured using a newly built CRISP panel for the county's 35,000 safety-net clients. The health department will track total service units, evaluate how effectively uninsured ED patients are successfully enrolled into a medical home, and monitor trends in preventable hospital admissions to ensure an overall improvement in community health.

Chairman Sharfstein asked the Adventist team how they intend to measure and observe the specific impact of their planned investments into time-sensitive, medically necessary surgical care.

**Dr. Neil Roy, Emergency Room Physician**, responded that the primary indicator of success will be a measurable reduction in the time from an initial surgical request to the actual delivery of operative care, specifically targeting local community surgeons who are currently facing extreme backlogs. He explained that a critical shortage of available operating room schedule slots, known as "block time," has forced independent providers to book urgent oncologic cases such as breast cancer surgeries four to six months in advance rather than the clinically ideal two-week window. By transferring the fixed capacity from the closed Germantown facility to Shady Grove, Adventist plans to expand the availability of operative supply capacity and closely track how effectively this extra block time alleviates surgeon waitlists for the county's patients.

Chairman Sharfstein requested a motion to adopt the staff's Final Recommendation for the Adventist Germantown Emergency Room Closure. Commissioner Maine moved to approve the staff's Recommendation, seconded by Commissioner Johnson. **The motion passed unanimously in favor of the staff's Final Recommendation.**

## **ITEM IX** **REPORT FROM THE EXECUTIVE DIRECTOR**

### **New Staff Announcement**

Dr. Jon Kromm, Executive Director, introduced the two new staff members in the Center for Population Based Methodologies at the HSCRC:

#### **Amelia Wallace**

Dr. Wallace joins the Commission as a Chief. Prior to joining the HSCRC, she was an assistant scientist in the Department of Epidemiology at the Johns Hopkins Bloomberg School of Public Health. Her research has focused on how cardiometabolic conditions develop and progress at the population level. She has also worked on quality-of-care data collection and analysis and brings a strong background in biostatistics.

#### **Oluwadunsin (Dunsin) Akinyemi**

Ms. Akinyemi joins the Commission as a Quality Fellow. She is a public health and health informatics professional with over four years of experience in healthcare analytics, program evaluation, and data-driven strategy. She has contributed to impactful work throughout her career with organizations such as the National Institutes of Health, the Department of Veterans Affairs, and the Maryland Hospital Association.

### **Model Monitoring**

Ms. Deon Joyce, Chief of Hospital Rate Regulation, reported on the Medicare Fee-for-Service (FFS) data through December 2025 (for claims paid through March 2026). The data showed that Maryland's Medicare hospital spending per capita growth was favorable when compared to the nation. Medicare non-hospital spending per capita and Total Cost of Care (TCOC) spending per capita were both favorable when compared to the nation. The Medicare TCOC guardrail is 0.61 percent above the nation through December 2025, and Maryland Medicare hospital and non-hospital growth through December resulted in a savings of \$79.9 million.

### **Policy Calendar Update**

Dr. Kromm provided an update on the HSCRC policy timeline, noting that while little has changed, the Commission is steadily progressing toward the main agenda item: the proposed update factor. Over the next few months, upcoming items will include policies on global budget carve-outs and care innovation, though the HOPE proposal has been shifted from May to June. Additionally, ongoing work on inpatient length of stay is planned to be presented in June. The multi-agency drafting of proposals for the all-payer total cost of care growth and primary care investment targets has experienced a slight delay and is expected to instead be ready for public comment later in the summer.

### **Legislative Updates and HSCRC Regulations Evaluation**

Dr. Kromm outlined several agency requirements detailed in this year's Joint Chairman's Report, highlighting the specific reports the Commission will lead. Notably, the Commission will take the lead on a report regarding incentives for Medicare Advantage (MA) plans under the AHEAD model, which is due in January 2027.

Additionally, the Commission will spearhead a new report on temporary staffing contracts, clarifying that this is a brand-new initiative requiring additional reporting from hospitals and not related to last year's report. The Commission is also slated to lead an ongoing evaluation and update on primary care programs and initiatives, specifically evaluating the MDPCP program, alongside a 2026 assessment of the market and the need for stabilization.

For other reports, the Commission will act in a supportive or collaborative capacity:

- The Commission will provide necessary data to support the MDH on a report regarding financing for long-acting injectables.
- It will also assist the Maryland Health Care Commission (MHCC), which is leading a report on on-call payments for trauma centers.
- Finally, in conjunction with the MHCC, the Commission has already begun discussions and will leverage existing work to conduct a joint study on bed capacity in hospitals and post-acute settings.

In compliance with the Regulatory Review and Evaluation Act, Dr. Kromm announced that the HSCRC is initiating its mandatory eight-year review of agency regulations. This statutory process requires the submission of both a formal work plan and a comprehensive evaluation report outlining any proposed regulatory amendments, repeals, or restructurings. To gather necessary feedback, the agency is launching a structured, two-part public comment process, with all supporting materials and notices being hosted directly on the HSCRC homepage.

The first phase of this process invites the public to submit comments on the current regulations by the close of business on June 12, which will be used to compile the draft evaluation report. Following the report's submission on or before October 1, 2026, a notice will be published in the *Maryland Register* to kick off the second phase. This will open a final 60-day public comment and inspection period to ensure thorough community review before the evaluation is finalized.

**No action was taken on this agenda item.**

#### **ITEM X** **DRAFT RECOMMENDATION: CRISP HIE FUNDING-FY2027**

Ms. Erin Schurmann, Associate Director, Strategic Initiatives and Ms. Megan Priolo, DrPH, MHS, Executive Director of the Chesapeake Regional Information System for our Patients (CRISP) presented the *Draft Recommendation on CRISP HIE Funding FY2027*, (see “*Draft Recommendation: CRISP HIE Funding – FY2027*” available on the HSCRC website).

Dr. Priolo opened her remarks by highlighting the organization's long-standing role as Maryland's designated health information exchange (HIE) and health data utility. Celebrating 17 years of service, she noted that while CRISP's technology model has successfully scaled to 12 other states, local human and policy collaboration remains essential to its success. Demonstrating the network's massive reach, she reported that CRISP supports nearly 17,000 active users and delivered 15.5 million unique alerts in the past 90 days.

To keep pace with the evolving healthcare landscape, Dr. Priolo outlined several new system updates and state partnerships:

- CRISP is now connected to all Maryland pharmacies for all dispensed medications and has introduced a grouped, flowchart-style "lab timeline view" to improve provider workflows.
- Additionally, CRISP is advancing tracking tools for the AHEAD model, facilitating automated referrals for the MDH's "Food is Medicine" pilot, and partnering with the Department of Human Services (DHS) and Medicaid on the HR1 initiative to streamline patient benefit eligibility.
- She also shared that a vendor will soon be selected for the Rural Health Clearinghouse data project, a major milestone six years in the making that will bring crucial transactional data into CRISP.

Dr. Priolo presented CRISP's funding recommendation ahead of the upcoming Commissioners' vote. The request for the upcoming fiscal year is set at \$10,900,000, which is lower than requests from prior years but consistent with the previous cycle aside from standard inflation adjustments. She noted that while the HSCRC assessment itself has decreased by a couple of million dollars compared to last year's request, the overall funding total reflects an increase driven by new priorities being conducted jointly with MDH.

Chairman Sharfstein asked whether CRISP's proposed budget and its overall relationship with the department provide the organization with enough resources and flexibility to support the HR1 implementation. Ms. Priolo responded that while "whatever is necessary" is a broad standard to guarantee, she believes CRISP is well-suited to support the HR1 implementation work based on what is currently known about the project's requirements.

**No action was taken on this agenda item.**

**ITEM XI**  
**DRAFT RECOMMENDATION: UPDATE FACTOR-FY2027**

Mrs. Caitlin Cooksey, Deputy Director, Hospital Rate Regulation and Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, presented the Staff's Draft Recommendation: Update Factor FY2027 (see "Draft Recommendation: Update Factor FY2027" available on the HSCRC website).

Ms. Cooksey presented the draft update factor recommendation, which balances hospital operational readiness with the goals of the state waiver while ensuring fairness for payers, hospitals, and consumers. Under the draft fiscal year 2027 recommendation:

- The gross inflation allowance is set at 3.37 percent (including a 0.2 percent catch-up methodology).
- \$50 million is allocated for HOPE as a care coordination line item.
- She noted a 0.4 percent allocation for the financial methodology set-aside, which is higher than the previous year due to lower-than-usual rate application outputs and a small increase in uncompensated care (UCC).
- She also highlighted that the initial 0.19 percent demographic adjustment and the resulting 3.65 percent fiscal year revenue growth will both be revised downward in the final recommendation due to an updated demographic value of 0.12 percent.

Ms. Cooksey addressed specific adjustments for specialty hospitals such as Mount Washington Pediatrics and regulated psychiatric facilities which operate on variable costs rather than global budget revenues. Their proposed update is set at 2.57 percent, factoring in the 3.37 percent gross inflation minus a 0.8 percent productivity adjustment drawn from the IPPS draft rule. She acknowledged that stakeholders have submitted comment letters requesting a suspension of this productivity adjustment, a topic that will be further addressed in the Final Recommendation. Additionally, because the state's waiver tests operate on a calendar year rather than a fiscal year, she noted that the fiscal revenue growth converts to a projected calendar year revenue growth of 5.15 percent over CY 2025.

Ms. Cooksey demonstrated the long-term affordability of these updates under the waiver guidelines, which target a 3.58 percent annual growth limit. Data projections through 2026 show that the cumulative growth of all-payers in state hospital charges remains safely below both the contract target and the cumulative Gross State Product (GSP) growth per capita. This affordability is further validated by a rolling five-year GSP test, which confirms that cumulative in-state charge growth has consistently remained below per capita GSP growth across every five-year period reviewed.

Mr. Henderson explained how the 5.15 percent calendar year hospital revenue growth translates into performance on the federal Medicare savings test. Because 2026 marks Performance Year 1 under the new federal AHEAD model, the calculation has undergone a significant transition. The state faces a baseline savings target of 0.13 percent equivalent to approximately \$16 million to \$17 million which must be reached for the year. He noted that these savings requirements are cumulative over time; for instance, the subsequent year's target rises to 0.34 percent because it stacks the new year's target onto the previous benchmark.

The biggest structural modification under the AHEAD model is how the national trend baseline is established. Instead of relying on raw national claims data shared directly by CMS as was done previously, the controlling indicator is now tied to the United States Per Capita Cost (USPCC) trend set by the Office of the Actuary for Medicare Advantage (MA). The basic formula

takes Maryland's 2023 baseline, adjusts it for national acuity through risk scoring, trends it forward using interim USPCC rates for 2024 and 2025, factors in the 2026 projected trend of 4.29 percent, and finally subtracts the required savings component to generate the state's percentage target.

A significant point of contention involving the current USPCC baseline is that the trend line was intentionally suppressed by CMS for 2024, 2025, and 2026. This suppression was enacted nationwide to correct a technical error where Graduate Medical Education (GME) costs were being double-counted to the benefit of MA plans. He noted that because this artificial reduction is an MA-specific programmatic adjustment, it should not penalize Maryland under the AHEAD test. While the state has strongly petitioned the Center for Medicare and Medicaid Innovation (CMMI) to remove this suppression from Maryland's scoring, a final federal decision is still pending.

To transparently navigate this administrative uncertainty, the staff developed two distinct modeling scenarios for the industry to review:

- **Scenario One:** Assumes the strict USPCC trend remains as currently released, without any federal adjustments to the GME suppression. Under this model, combining Maryland's 5.15 percent hospital growth with national non-hospital spending projections yields a 5.2 percent total growth rate for the state. Because the unadjusted federal target would sit at a restrictive 4.0 percent, Maryland would miss its current-year target and face a cumulative dissaving of roughly \$80 million in 2026.
- **Scenario Two:** Models the impact if CMS ultimately agrees to correct the GME suppression for the state. Under this favorable tracking, Maryland's projected growth remains at 5.2 percent, but the allowed national trend baseline rises to 5.3 percent. Crucially, this correction retroactively lifts the allowed baseline for the interim years 2024 and 2025 as well. This shifts the cumulative outcome dramatically, placing Maryland at 2.7 percent better than the federal target. This variance equates to roughly \$270 million in total healthcare savings, which aligns cleanly with historical trends observed under the previous Total Cost of Care (TCOC) model.

Mr. Henderson concluded by highlighting several open accounting variables that will cause these projections to fluctuate before the final update factor is locked in. Staff is actively working with CMMI to confirm minor changes to how actuals are calculated, waiting on final sign-offs for tracking methodologies, and utilizing 2025 risk scores as an estimate until official 2026 Hierarchical Condition Category (HCC) data is compiled. Resolving the overarching GME suppression remains the highest operational priority to eliminate the massive \$350 million variance between two projection scenarios.

Ms. Cooksey presented the staff's Draft Recommendation as follows:

**For Global Revenues:**

- Provide all hospitals with a gross inflationary increase of 3.37 percent, including an additional 0.20 percent to support revenue needs based on historical underfunding of inflation, and 0.06 percent allocated based on each hospital's proportion of drug costs.
- Provide an overall increase of 3.65 percent for revenue (including a net increase to uncompensated care) and 3.25 percent per capita for hospitals under Global Budgets. In addition, the staff is proposing to split the approved revenue into two targets: a mid-year target and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target, and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

**For Non-Global Revenues** (including psychiatric hospitals and Mt. Washington Pediatric Hospital):

- Provide an overall update of 3.17 percent for inflation and additional inflation of 0.20 percent and apply a productivity offset of 0.80 percent for a total update of 2.57 percent.

**No action was taken on this agenda item.**

**ITEM XII**  
**HEARING AND MEETING SCHEDULE**

June 10, 2026,

Time to be determined  
4160 Patterson Ave.  
HSCRC Conference Room

There being no further business, the meeting was adjourned.

**Closed Session Minutes  
of the  
Health Services Cost Review Commission  
May 13, 2026**

Chairman Sharfstein stated the reasons for Commissioners to move into administrative session, under the authority provided by the General Provisions Article §3-103, §3-104 and §3-305 for the purpose of discussing the administration of the Model and receiving legal advice from Counsel.

Upon a motion made in public session, Chairman Sharfstein called for an adjournment into closed session.

The administrative session was called to order by motion at 12:05 p.m.

In addition to Chairman Sharfstein, Commissioners Elliott, Johnson, Maine, McCann and Sabi were in attendance.

**Joining by Zoom: Commissioner Blum**

Staff members in attendance were Jon Kromm, Jerry Schmith, William Henderson, Claudine Williams, Christa Speicher, Alyson Schuster, Cait Cooksey, Erin Schurmann, Bob Gillion and William Hoff.

Also attending were Assistant Attorneys General Stan Lustman and Ari Elbaum, Commission Counsel.

**Item I**

Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, updated the Commission, and the Commission discussed the TCOC model monitoring.

**Item II**

Mr. Henderson also updated the Commission, and the Commission discussed the FY26 Hospital Financial Condition through February 2026.

**Item III**

Mr. Stan Lustman, Commission Counsel, provided legal advice to the Commissioners on Commission methodology.

The Closed Session was adjourned at 12:25 p.m.



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## Partial Rate Application 2695N: Establishment of 340B rates for TidalHealth

June 10, 2026

# Staff Recommendation:

## Introduction

On April 10, 2026, Tidal Health Inc. submitted a partial rate application to the HSCRC requesting certain outpatient infusion rates for Tidal Health Peninsula Regional (THPR) associated with services that, for purposes of the federal 340B Drug Pricing Program, are also designated as child-site services of Tidal Health Atlantic General (THA) to be effective June 15, 2026.

## Staff Evaluation

HSCRC policy is to set the rates for new services at the lower of the statewide median or a rate based on the hospital's projections. Based on the information received, the requested rates are lower than the statewide average for similar services offered for child sites of 340B programs. Staff is working to reconcile the associated revenue shift that was included in this request.

## Recommendation

Staff found the requested outpatient infusion rates associated with services provided through THA as a 340B child site of THPR to be reasonable. After reviewing the application, staff recommend that Tidal Health's request be approved because: 1) it will enable services to be provided on the campus of Tidal Health Atlantic as a child site of Tidal Health Peninsula Regional; and 2) it will produce overall Medicare savings as infusion services are weighted more heavily to Medicare.

Staff also recommend that the following rates for the infusion clinic services provided at Tidal Health Atlantic be approved and added to THPR's approved rate order and GBR effective June 15, 2026:

1. CL-340B rate of \$52.83 per RVU
2. LAB-340B rate of \$2.81 per RVU
3. CDS-340B rate of \$1.55 per RVU

In addition, Staff will collaborate with Tidal Health to implement the necessary revenue adjustments in the RY27 rate orders.

<b>IN RE: THE PARTIAL RATE</b>	*	<b>BEFORE THE HEALTH SERVICES</b>
<b>APPLICATION OF</b>	*	<b>COST REVIEW COMMISSION</b>
<b>PENINSULA REGIONAL</b>	*	<b>DOCKET: 2026</b>
<b>MEDICAL CENTER</b>	*	<b>FOLIO: 2505</b>
<b>SALISBURY, MARYLAND</b>	*	<b>PROCEEDING: 2695N</b>

**Staff Recommendation**  
**June 10, 2026**

## **Introduction**

On April 10, 2026, Tidal Health Inc. submitted a partial rate application to the HSCRC requesting certain outpatient infusion rates for Tidal Health Peninsula Regional (THPR) associated with services that, for purposes of the federal 340B Drug Pricing Program, are also designated as child-site services of Tidal Health Atlantic General (THA) to be effective June 15, 2026.

Tidal Health is requesting the following rates:

CDS (Costs of Drugs Sold)-340B/OID (Outpatient Infusion/Oncology)-340 Drug Rate Center - 1.5477 per RVU

Clinic Rate Center - 52.8325 per RVU

Lab Rate Center – 2.8074 per RVU

Under HSCRC law, the term “hospital services” includes hospital outpatient services of a hospital that are designated as part of another hospital under the same merged asset system to make it possible for the other hospital to participate in the 340B program.

Tidal Health requests that effective June 15, 2026, infusion clinic services provided at THA be approved to begin operations as part of the THPR oncology program. The outpatient infusion clinics located at THA will be able to operate as an off-site provider-based child-site of Tidal Health Peninsula Regional in accordance with Medicare’s rules for provider-based status. As a result of this request, the child-site at THA will be able to participate in the 340B outpatient drug discount program under THPR’s eligibility.

Additionally, Tidal Health is requesting that the revision of rates not be realigned until a full year of service.

## **Staff Findings**

Staff found the requested outpatient infusion rates associated with services provided through THA as a 340B child site of THPR to be reasonable. As a matter of practice, staff uses the lesser between the rate requested or the statewide median rate. As these requested rates are less than the statewide median, staff will use the rates requested.

## **Recommendation**

After reviewing the application, staff recommend that Tidal Health's request be approved because: 1) it will enable services to be provided on the campus of Tidal Health Atlantic as a child site of Tidal Health Peninsula Regional; and 2) it will produce overall Medicare savings as infusion services are weighted more heavily to Medicare.

Staff also recommend that the following rates for the infusion clinic services provided at Tidal Health Atlantic be approved and added to THPR's approved rate order and GBR effective June 15, 2026:

1. CL-340B rate of \$52.83 per RVU
2. LAB-340B rate of \$2.81 per RVU
3. CDS-340B rate of \$1.55 per RVU

In addition, Staff will collaborate with Tidal Health to implement the necessary revenue adjustments in the RY27 rate orders.



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# Alternative Method of Rate Determination

University of Maryland Medical Center

Request for Extension

June 10, 2026

# University of Maryland Medical Center- Request for Extension

- On March 3, 2026, in accordance with authority granted by the Commission, Staff approved a 3-month extension of the alternative rate arrangement between University of Maryland Medical Center(UMMC) and Cigna Health Corporation (Cigna), Proceeding 2670A. This extension expires on June 30, 2026.
- On May 7, 2026 UMMC requested the Commission extend the rate arrangement an additional three months to complete contract negotiations with Cigna.
- Staff's review of historical data has shown the rate agreement has been favorable.
- Staff recommends the 3-month extension be granted contingent upon completion of negotiations by September 30, 2026. If negotiations are not completed by this date, staff recommends that no more services be provided under arrangement until a new application is submitted.



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# Request For Extension of Approval

University of Maryland Medical Center

June 10, 2026

### Background

On March 3, 2026, in accordance with the authority granted to it by the Commission, Staff approved a 3-month extension of the Commission's approval of the alternative rate arrangement between the University of Maryland Medical Center (UMMC) and Cigna Health Corporation. (Cigna), for solid organ and bone marrow transplants, Proceeding 2670A. The extension expires on June 30, 2026. However, UMMC and Cigna have not yet completed negotiations to extend the arrangement.

### Request

UMMC requests that the Commission extend its approval for an additional three months to September 30, 2026, to complete negotiations.

### Findings

Staff found that the experience under the current arrangement has been favorable.

### Staff Recommendation

Staff recommends that the Commission grant UMMC's request for a three-month extension of its approval, provided that if the negotiations are not completed before the expiration of this extension, the arrangement will end and no further services may be provided under the arrangement until a new application is approved.



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# Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

June 10, 2026

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2026
SYSTEM	*	FOLIO:	2508
BALTIMORE, MARYLAND	*	PROCEEDING:	2698A

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## **I. INTRODUCTION**

On May 28, 2026, Johns Hopkins Health System (“System”) filed a renewal application on behalf of its member hospital, Johns Hopkins Bayview Medical Center (the “Hospital”), for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a revised global price arrangement with self-pay patients for reproductive health services. The Hospital requests that the Commission approve the arrangement for one year beginning July 1, 2026.

## **II. OVERVIEW OF APPLICATION**

The contract will continue to be held and administered by Johns Hopkins Healthcare, LLC. (“JHHC”), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

## **III. FEE DEVELOPMENT**

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

## **IV. IDENTIFICATION AND ASSESSMENT OF RISK**

The Hospital will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between JHHC and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

## **V. STAFF EVALUATION**

Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the hospitals can continue to achieve a favorable performance under the arrangement.

## **VI. STAFF RECOMMENDATION**

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination with self-pay patients for reproductive health services for one-year beginning July 1, 2026. The Hospital must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

# Request to Access HSCRC Confidential Patient Level Data from Johns Hopkins Center for Population Health IT

## Staff Recommendation

1. HSCRC staff recommends that the request by **Johns Hopkins University, Bloomberg School of Health's Center for Population Health Information Technology** for the data for **Calendar Years 2019 through 2025** be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.



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**Final Staff Recommendation for Access to the  
HSCRC Confidential Patient Level Data Request from  
Johns Hopkins Center for Population Health IT**

Health Services Cost Review Commission  
4160 Patterson Avenue, Baltimore, MD 21215

This is a final recommendation for Commission consideration at the June 10, 2026, Public Commission Meeting.

## SUMMARY STATEMENT

Johns Hopkins University, Bloomberg School of Health's Center for Population Health Information Technology (CPHIT) requests access to the Statewide Confidential Hospital Discharge Data Sets (Inpatient) and Hospital Outpatient Data Sets (Outpatient) collected by the Health Services Cost Review Commission (HSCRC). This request is intended to facilitate research aimed at identifying predictive models and factors associated with suicide. The data will support the development of new methods to identify clinical and social patterns that contribute to these outcomes. While the National Institute of Mental Health (NIMH) originally funded CPHIT to create the Maryland Suicide Data Warehouse (MSDW), NIMH has since expanded the research aims through an R01 grant to include a refresh of existing data and acquiring new data from different sources and replication of descriptive findings, develop and assess hypothesis-driven techniques to predict suicide death, explore hypothesis-generating use cases of the MSDW, and devalue the generalizability of data sources and methods.

## OBJECTIVE

The project aims to identify individuals at a higher risk of suicide and subsequently provide insights on therapies and possible targeted interventions to improve care for patients exhibiting signs of suicide ideation. To achieve this, researchers have created a merged database by linking existing individual and geo-level data sources, including HSCRC's case mix data (inpatient and outpatient files), MHCC's All Payer Claims Database, the Maryland Office of the Medical Examiner (OCME) data, Vital Statistics Death data, and clinical data from Johns Hopkins Hospital, Luminis Health, and Tidal Health for individual-level information, alongside American Community Survey (ACS) and other publicly available sources aggregated at a census block group level for geo-level data. Individual data will be securely processed by CRISP using their master patient index and geocoded information to link encounters and geo-level data, followed by anonymization, ensuring only limited PHI (dates and census block group information) is shared with the research team. The resulting knowledge from this study is anticipated to provide a basis for understanding the pathways to suicide and enable earlier intervention by clinicians and individuals.

DDA received approval from the MDH Strategic Data Initiative (SDI) office on **May 22, 2026**.

*(The Data will not be used to identify individual patients. The Data will be retained by Johns Hopkins School of Public Health's Center for Population Health Information Technology until project completion on December 31, 2030. At that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.)*

## REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee is composed of representatives from HSCRC and the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements listed below and to make recommendations for approval to the HSCRC at its monthly public meeting.

1. The proposed study or research is in the public interest;
2. The study or research design is sound from a technical perspective;
3. The organization is credible;
4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations; and
5. The organization has adequate data security procedures in place to ensure protection of patient

confidentiality.

The Review Committee unanimously agreed to recommend that Johns Hopkins University, Bloomberg School of Health's Center for Population Health Information Technology be given access to the Data. As a condition for approval, CPHIT will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.

#### **STAFF RECOMMENDATION**

1. HSCRC staff recommends that the request by Johns Hopkins University, Bloomberg School of Health's Center for Population Health Information Technology to the basic inpatient and outpatient confidential discharge data for Calendar Years 2019 through 2025 be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.

# Request to Access HSCRC Confidential Patient Level Data from University of Maryland, Baltimore

## STAFF RECOMMENDATION

1. HSCRC staff recommends that the request from the **University of Maryland Baltimore** for access to the grouped inpatient and outpatient confidential discharge data for **Calendar Years 2017 through 2025** be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.



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**Final Staff Recommendation for Access to the  
HSCRC Confidential Patient Level Data Request from  
University of Maryland, Baltimore**

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

This is a final recommendation for Commission consideration at the June 10, 2026, Public Commission Meeting.

## SUMMARY STATEMENT

The University of Maryland, Baltimore (UMB) requests access to the Statewide Confidential Hospital Discharge Data Sets (Inpatient) and Hospital Outpatient Data Sets (Outpatient) collected by the Health Services Cost Review Commission (HSCRC) to support a federally-funded research study evaluating the effectiveness of the Medherent™ intervention. This request is for grouped inpatient and outpatient data for Calendar Years 2017 through 2025 and includes linkage through CRISP. The National Institute of Mental Health (NIMH)-funded project is designed to measure the impact of existing and enhanced Medherent interventions on psychiatric and medical care utilization, medication adherence, clinical outcomes, and associated healthcare costs among adults with serious and persistent mental illness (SPMI), including individuals with schizophrenia, bipolar disorder, and major depression. Access to HSCRC data will allow investigators to analyze hospitalization patterns, laboratory results available in hospital records, and other service utilization indicators necessary to evaluate the effectiveness and public health impact of the Medherent device. The study aims to assess how technology-enabled medication support may increase autonomy, improve medication adherence, and enhance care coordination within community mental health settings. These data will help determine whether Medherent contributes to reductions in healthcare utilization, improved clinical outcomes, and potential cost savings for mental health provider agencies.

## BACKGROUND

The purpose of this request is to facilitate CRISP-assisted linkage of study participants to HSCRC's statewide grouped inpatient and outpatient confidential discharge datasets for Calendar Years 2017–2025. Linked case-mix data are essential to assessing:

- Hospital-based service utilization
- Emergency and inpatient encounters
- Trends in healthcare costs
- Clinical outcomes related to medication adherence
- Benefits associated with technology-enabled care coordination

The Medherent device is intended to support medication self-management, reduce the need for staff-administered dosing, improve remote care engagement, and enhance real-time monitoring of health indicators. These improvements may lead to better psychiatric and physical health outcomes for individuals with SPMI, while offering community mental health agencies opportunities to allocate staff resources more efficiently.

The public health benefit is substantial. Strengthening medication adherence and care coordination among individuals with complex behavioral health needs can reduce hospitalizations, support recovery, and alleviate pressure on Maryland's mental health and hospital systems.

Informed consent was obtained from all study participants. Risks to participants primarily relate to the possibility of a breach of confidentiality; however, UMB has implemented extensive safeguards, including secure server-based storage, VPN-restricted access, password protections, activity logging, encryption of data in motion and at rest, and adherence to institutional IT policies aligned with NIST and FedRAMP standards.

University of Maryland, Baltimore received IRB approval and MDH Strategic Data Initiative (SDI) approval on **May 22, 2026**.

*(The Data will not be used to identify individual patients. Identifiers used for CRISP linkage will be destroyed immediately following linkage. De-identified HSCRC case mix data linked to Medherent study IDs will be retained only for the duration of the project. In accordance with the University of Maryland, Baltimore IRB requirements and the study protocol, all data will be stored on secure, encrypted servers with restricted access and will be destroyed at the conclusion of the study period on September 30, 2030. A Certification of Destruction will be submitted to the HSCRC confirming that all HSCRC data and any derivative files have been permanently deleted.)*

### **REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA**

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee (“the Review Committee”). The Review Committee included representatives from the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements listed below and to assist HSCRC staff in making recommendations for approval to the Commission at its monthly public meeting:

1. The proposed study or research is in the public interest;
2. The study or research design is sound from a technical perspective;
3. The organization is credible;
4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations; and
5. The organization has adequate data security procedures in place to ensure protection of patient confidentiality.

The Review Committee voted unanimously to give the University of Maryland, Baltimore, access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.

### **STAFF RECOMMENDATION**

1. HSCRC staff recommends that the request from the University of Maryland, Baltimore for access to the grouped inpatient and outpatient confidential discharge data for Calendar Years 2017 through 2025 be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.

# HSCRC AHEAD Model Policy Timeline

## June 2026

# HSCRC AHEAD Model Policy Timeline

## Policy Updates Already Planned

The timeline for these items has already been discussed at HSCRC meetings - **COMPLETE**

## Required Changes for AHEAD Implementation

The AHEAD Model will require changes to some core HSCRC financial policies.

## AHEAD-Related Policy Changes

Policy development work not explicitly required by the AHEAD Model, but where policy changes can promote success.

## Policy Changes Involving Multiple Agencies

These items involve significant leadership outside HSCRC, with a role for HSCRC in policy development and implementation.\*

*\* Coordinated by Regulatory Working Group*

# Key to Timeline Descriptions

**S: Staff**

HSCRC staff are working on policy development and implementation.

**W: Workgroup**

The policy topic will be discussed by an HSCRC workgroup.

**C: Call for Public Input**

The HSCRC will request public comment for policy topics, *i.e.*, that will not ultimately require a Commission vote.

**T: Topic discussed at Commission Meeting**

The Commission will discuss ideas for policy topics as generated by a call for public input.

**D: Draft Recommendation**

HSCRC staff present a draft recommendation at the Commission meeting.

**P: Public Comment for Recommendation**

Stakeholders submit comments in response to a draft recommendation.

**F: Final Vote**

HSCRC staff present a final recommendation for Commission discussion and vote.

*Italics indicate that timeline is contingent upon CMMI action.*

# Required Changes for AHEAD Implementation

	Oct. 2025	Nov. 2025	Dec. 2025	Jan. 2026	Feb. 2026	Mar. 2026	Apr. 2026	May 2026	Jun. 2026
<b>B. HSCRC Policy Changes Required for AHEAD Implementation</b>									
<i>Global Budget Carveouts</i>				<i>W</i>	<i>C/W</i>	<i>W</i>	<i>S</i>	<i>S</i>	<i>D</i>
<i>Aligning Quality Metrics with CMS</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>
<i>Major Capital Program</i>	<i>S</i>	<i>T</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>
<i>Medicare Hospital Global Budget supplemental payments and exclusions</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>	<i>S</i>
Care Innovation (HOPE)				C	W	D	P	S	F
GBR 2028 Policy Review				S	S	S	S	S	S

- **Today's Agenda**
  - Global Budget Carve-outs: Draft Recommendation
  - Care Innovation (HOPE): Final Recommendation

Key to Table		
S: Staff	T: Topic Discussed at Commission Meeting	F: Final Vote
W: Workgroup	D: Draft Recommendation	<i>Italics indicate timeline is contingent upon CMMI action.</i>
C: Call for Public Input	P: Public Comment for Recommendation	

# AHEAD-Related HSCRC Policy Changes

	Oct. 2025	Nov. 2025	Dec. 2025	Jan. 2026	Feb. 2026	Mar. 2026	Apr. 2026	May 2026	Jun. 2026
<b>C. AHEAD-Related HSCRC Policy Changes</b>									
Physician Costs			C	T					
<i>Efficiency Policy (shifted to November)</i>									
Preventable Utilization - Length of Stay	S	W	S	S	T	S	D	P	F
Health System Transformation Policy				S	C	T	S	S	S

- Today's Agenda
  - Inpatient Length of Stay: Final Recommendation

Key to Table		
S: Staff	T: Topic Discussed at Commission Meeting	F: Final Vote
W: Workgroup	D: Draft Recommendation	<i>Italics indicate timeline is contingent upon CMMI action.</i>
C: Call for Public Input	P: Public Comment for Recommendation	

# Multi-Agency Priorities: Updates and Upcoming Opportunities

Workstream	Status
Maryland-Specific Metrics for AHEAD	Awaiting measure feedback from CMMI
Graduate Medical Education and Workforce*	Hosted focus groups in April; draft report anticipated for June/July
Denials	Adverse Decisions Workgroup has meetings scheduled through the fall; report due December 2026
Medicare Advantage Market Stabilization*	Differential for CY 2027 under development; metrics under development
Post-Acute Strategy*	Hosted focus groups in March and April; draft report anticipated for June/July
Cost-Shifting*	Will be part of FY 2028 update factor; metrics under development
All-Payer Total Cost of Care Growth and Primary Care Investment Targets*	All-Payer Targets Advisory Committee and Primary Care Investment Workgroup both met in April; public comment period June 15-29
Choice and Competition*	Information-gathering in progress; draft policy options expected summer 2026
ED Wait Times Commission	Commission and subgroup meetings being rescheduled due to the HSCRC July commission meeting date. Updates will be posted on the website.

\*Coordinated by Regulatory Working Group



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## Update Factor Final Recommendation

June 10, 2026

# Final Recommendations

## For Global Revenues:

- (a) Provide all hospitals with a gross inflationary increase of 3.37 percent, including an additional 0.20 percent to support revenue needs based on historical underfunding of inflation, and 0.06 percent allocated based on each hospital's proportion of drug costs.
- (b) Provide an overall increase of 4.07 percent for revenue (including a net increase to uncompensated care) and 3.95 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets: a mid-year target and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target, and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.
- (c) **DRAFT RECOMMENDATION:** Provide additional funding related to uncompensated care to the Maryland Health Benefit Exchange Fund of 0.4 percent to support reinsurance and subsidies for marketplace enrollees and 0.1 percent to increase the reserve held in the HSCRC's Uncompensated Care Fund to be released as additional uncompensated care emerges. This element is a draft recommendation and will the 0.5 percent will be removed from the update factor if the final recommendation is not approved subsequently.

## For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- (a) Provide an overall update of 3.17 percent for inflation and additional inflation of 0.20, for a total update of 3.37 percent. Suspend the productivity adjustment for RY 2027.

# Changes from Draft to Final Recommendation

- Demographic Adjustment has been updated from 0.38% to 0.12% to reflect full population change back to 2020 census
- Surge Funding has been updated with a 9 month estimate, which updated the 6 month value from 0.22% to 0.19%, suggesting a slower surge season than past years
- \$48.7 million for CTI Transition funding was included as part of the final recommendation. These dollars will be provided based on system level earnings that would have been paid out as part of the CTI rewards in RY2027 for the RY2025 performance year. This funding is one-time funding.
- 0.50% included in UCC to help mitigate marketplace declines and medicaid losses.
  - 0.40% in funding to the Maryland Health Benefit Exchange Fund to provide additional reinsurance and state subsidies for marketplace enrollees
  - 0.10% to increase the reserves held in the UCC Fund
  - Staff also are considering options for providing funding to FQHCs to expand services to reduce the unnecessary use of hospital services. This is not included in this recommendation due to the complexity required but Staff are interested in comments on whether and how to direct uncompensated care funding to FQHCs, so that uninsured individuals can receive care in the most appropriate setting.

# Stakeholder Comments

# Comment Letters Received

## Letters were received from:

1. Brook Lane
2. Mount Washington Pediatric Hospital (MWPH)
3. J. Kent McNew
4. Sheppard Pratt
5. Maryland HealthCare for All (MHCA)
6. Maryland Hospital Association (MHA)
7. Adventist HealthCare
8. Health Means Everything Consumer Alliance (HME)
9. Frederick Health
10. John Hopkins Health System (JHHS)
11. MedStar Health
12. Carefirst
13. University of Maryland Medical System (UMMS)
14. Luminis Health

## Comments generally focused on 9 areas:

1. Monitor Inflation Throughout the Rate Year
2. Prospectively Adjust the UCC Provision in Rates
3. Provide Additional Funding to Support Hospital Readiness for H.R.1 and AHEAD
4. Distribute the National Demand Modifier Based on Age-Adjusted Demographic Growth
5. Delay HOPE Implementation Pending Access and Latent-Demand Concerns
6. Limit Hospital Revenue Growth and Update Factor Increases
7. Align HSCRC methodologies with AHEAD/CMMI
8. Fund CTI Rewards for RY 2025 performance
9. Discontinue the Productivity Adjustment for Non-GBR Hospitals

# 1. Monitor Inflation Throughout the Rate Year

- The Maryland Hospital Association (MHA) and its member hospitals expressed concern that economic volatility and current cost pressures, including rising energy and labor costs, may not be fully reflected in current forecasts. MHA requested that the Commission continue monitoring inflation throughout the rate year to ensure the inflation allowance remains adequate if actual inflation exceeds projections. Luminis Health noted that recent Producer Price Index trends for energy and supplies appear to exceed current S&P Global inflation projections. MedStar Health requested that the Commission consider suspending the inflation catch-up methodology for FY 2027 and provide the full underfunded inflation amount, which MedStar estimated would provide hospitals with an additional 0.25%. In contrast, CareFirst BlueCross BlueShield expressed concern regarding the calculation of the 0.20% inflation catch-up adjustment, stating that the most recent FY 2025 data was not incorporated into the corridor analysis. CareFirst recommended recalculating the inflation methodology using the most current available data and reiterated prior concerns regarding the selected base year for the policy.

*HSCRC Response: Staff review inflation with every quarter book that S&P publishes. The catch up methodology was specifically designed to provide additional inflation beyond the risk tolerance guardrail of 0.25%. Should actual inflation come in higher than what was funded and it trips the guardrail, Staff will provide additional inflation in line with the catch up methodology. Staff also think it is important to note that the guardrail was lowered last year from 1% to 0.25% as part of the RY 2026 Update Factor Recommendation and there were years where hospitals were overfunded, prior to the catch up methodology being put in place, that Staff did not remove inflation.*

*In response to CareFirst's concerns with not using the most current year available data. Staff do not consider inflation to be complete until 7 quarters of data have passed since the funded value was put into rates. Including a year that is incomplete adds an additional reconciliation to be completed as part of the process and would add unnecessary complexity. Staff do think it is important to note that while we don't include the most current year's actual inflation in the catch up methodology, we do include any catch up inflation that was included in that year's calculation.*

## 2. Prospectively Adjust the UCC Provision in Rates

- MHA, Adventist Health Care, John Hopkins Health System (JHHS), MedStar Health, Luminis Health and the University of Maryland Medical System (UMMS) requested that the Commission prospectively adjust the uncompensated care (UCC) provision in rates by 0.69% for RY 2027 to reflect projected Medicaid and Marketplace coverage losses resulting from federal policy changes. Additionally, they noted that under current policy, increases in UCC would not be reflected in rates until RY 2029, creating what Adventist described as an “operationally untenable” two-year lag while hospitals are already experiencing increased bad debt and charity care pressures.

*HSCRC Response: The State is considering various alternatives to mitigate the effects of the loss of coverage under Medicaid and Marketplace.*

### 3. Provide Additional Funding to Support Hospital Readiness for H.R.1 and AHEAD

- MHA, Adventist HealthCare, JHHS, MedStar Health, Luminis Health and UMMS requested that the Commission allocate an additional 0.30% to support hospital readiness for H.R.1 and the transition to AHEAD. Commenters stated that hospitals will need to make significant investments in staffing, revenue cycle operations, Medicare cost reporting, MS-DRG implementation, clinical documentation improvement, quality reporting alignment, and technology system upgrades to operate under bifurcated payment and regulatory systems beginning in 2028. Commenters also cited the administrative burden associated with assisting patients with Medicaid eligibility, coverage retention, and enrollment disruptions resulting from federal policy changes. MedStar Health noted that hospitals will be required to simultaneously manage differing payment, operational, and reporting requirements under both the Total Cost of Care and AHEAD frameworks, while UMMS expressed concern that monitoring, rather than proactively addressing, H.R.1-related impacts would leave hospitals responsible for bearing the financial risk associated with a broad range of potential outcomes.

*HSCRC Response: Hospitals received \$25 million in one-time funding in RY2025 and \$50 million in permanent funding in RY2026 for AHEAD preparation. Permanent funding will remain in rates in perpetuity and get inflated each year moving forward. Staff do not agree that additional funding related to AHEAD preparation is warranted at this time. In addition, should HOPE get approved by the Commission, Hospitals are keeping all revenue that was at risk of a clawback as part of the high value care plans and prior to that for PAU.*

## 4. Delay HOPE Implementation Pending Access and Latent-Demand Concerns

- Adventist HealthCare requested that Commission delay implementation of the Healthcare Outcome Payment Effort (HOPE) framework until latent-demand and access concerns are fully evaluated and coordination with CMS is established. Adventist expressed concern that the current improvement-only methodology could disadvantage already efficient, low total cost of care regions and stated that low utilization in some areas may reflect unmet need rather than efficiency. Adventist also recommended that Commission establish a framework to assess care access before implementing policies tied to TCOC performance.
- Luminis Health supports the intent of the HOPE program. However, before any funds are withheld from the update factor to support the program, additional detail is needed regarding how savings will be measured, how clinical interventions will be evaluated and approved, and what guardrails will be implemented to protect the integrity of the program.

*HSCRC Response: While implementation of HOPE is being delayed with applications during FY 27 and performance periods generally starting in FY 28, Staff do not view these concerns and continued care transformation efforts as mutually exclusive. Staff believe these issues can continue to be evaluated and coordinated with CMS concurrent with ongoing HOPE development and implementation activities. Concerns with HOPE will be evaluated as the Commission reviews the HOPE recommendation.*

## 5. Distribute the National Demand Modifier Based on Age-Adjusted Demographic Growth

- Adventist HealthCare & Frederick requested that the national demand modifier be distributed proportionally based on age-adjusted demographic growth rather than evenly across hospitals statewide. The Hospitals stated that the current methodology creates a disconnect between the purpose of the adjustment and its distribution because hospitals facing significantly different demographic pressures receive the same allocation. They emphasized that funding intended to address aging population impacts should be directed toward regions experiencing the greatest demographic growth. Luminis Health additionally expressed concern that insufficient recognition of age-adjusted population growth during the AHEAD base period could create long-term financial challenges for hospitals experiencing higher demographic growth.

*HSCRC Response: Staff believe there is conceptual validity to this request. There is added complexity with adding this change after results have already been shared with the industry. In addition, the impact is relatively small. Staff agree to consider this enhancement as part of the broader policy review during the transition to split global budgets under AHEAD.*

## 6. Limit Hospital Revenue Growth and Update Factor Increases

- The Maryland HealthCare for All (MHCA) and Health Means Everything Consumer Alliance (HME) organizations expressed concern about the cumulative impact of consecutive hospital revenue increases on Maryland consumers and urged the Commission to limit update factor increases while protecting access to affordable, high-quality care. Both organizations stated that hospital revenue growth should not outpace broader economic and wage growth and recommended treating the draft recommendation as a cap on potential increases given ongoing affordability pressures facing Marylanders. CareFirst also emphasized the importance of balancing hospital financial stability with affordability for Maryland consumers. CareFirst noted that Maryland Medicare hospital payments per capita grew faster than the national average in 2025 and encouraged the Commission to prioritize performance under the AHEAD Model savings tests when finalizing the update factor recommendation.

## 6. Limit Hospital Revenue Growth and Update Factor Increases

*HSCRC Response: Staff appreciate the comments provided by The Maryland HealthCare for All (MHCA) and Health Means Everything Consumer Alliance (HME) organizations. The Update Factor recommendation is a balance between fairness and equity for hospitals, payers, and consumers. One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the Medicare Agreement. Applied to all payers in the system, the update factor determination ensures that the increases to hospital rates borne by all purchasers of hospital services, including consumers, is reasonable and affordable. To ensure All-Payer affordability, Staff measures our projected update against the GSP target of 3.58% in our contract and the actual GSP since 2014. For all years measured, the All-Payer In State Hospital growth has been lower than the contract target and actual GSP. Should the projected Hospital growth ever be expected to grow beyond the contract target or actual GSP, staff would evaluate factors within the update to ensure continued affordability.*

## 7. Align HSCRC methodologies with AHEAD/CMMI

- UMMS encouraged the Commission to focus Staff efforts on aligning core methodologies with CMMI and transitioning to AHEAD. Specifically, they recommended prioritizing alignment, rather than divergence, on core issues such as carve outs, volume, and quality, while focusing on methodologies that represent the “core building blocks” for Commercial and Medicaid rate setting.

*HSCRC Response: Staff agree with these comments. Over the next six months of the calendar year, Staff will be working with stakeholders to align our current policies under AHEAD. There is a significant amount of consideration that will be going into this development. We appreciate the early feedback and ongoing support of stakeholders as we work to achieve alignment over the next several months.*

## 7. Align HSCRC methodologies with AHEAD/CMMI

- UMMS encouraged the Commission to focus Staff efforts on aligning core methodologies with CMMI and transitioning to AHEAD. Specifically, they recommended prioritizing alignment, rather than divergence, on core issues such as carve outs, volume, and quality, while focusing on methodologies that represent the “core building blocks” for Commercial and Medicaid rate setting.

*HSCRC Response: Staff agree with these comments. Over the next six months of the calendar year, Staff will be working with stakeholders to align our current policies under AHEAD. There is a significant amount of consideration that will be going into this development. We appreciate the early feedback and ongoing support of stakeholders as we work to achieve alignment over the next several months.*

## 8. Fund CTI Rewards for RY 2025 performance

- MedStar Health expressed concern regarding the retrospective elimination of Care Transformation Initiative (CTI) rewards and penalties for FY 2025 performance, stating that hospitals made substantial investments in care coordination, population health, and clinical integration infrastructure based on anticipated CTI incentives. MedStar requested that the Commission consider using a portion of the CTI set-aside funds to provide bridge funding through at least FY 2028 for hospitals with established, high-performing CTI programs.
- UMMS does not support ending the CTI policy without paying hospitals for their FY 2025 performance. UMMS and other commenters fully support a set aside in the update factor to fund hospitals and/or systems who have earned rewards within the CTI program.

*HSCRC Response: Staff have earmarked funding to provide to hospitals based on system level earnings that would have been paid out as part of the CTI rewards in RY2027 for the RY2025 performance year.*

## 9. Discontinue the Productivity Adjustment for Non-GBR Hospitals

Final Recommendation Inflation Breakdown: Specialty Hospitals	
Inflation	3.17%
Productivity Adjustment	<b>SUSPENDED</b>
Additional Inflation Support	0.20%
Gross Inflation Allowance	3.37%

- MHA, UMMS, JHHS, Luminis Health, Brook Lane, Mt. Washington Pediatric Hospital, Sheppard Pratt, and J. Kent McNew Family Medical Center requested that the Commission discontinue the proposed 0.80% productivity adjustment for non-GBR hospitals and provide specialty hospitals with the full 3.37% inflation allowance included in the draft recommendation. They stated that specialty behavioral health and pediatric providers face significant labor shortages, rising operating costs, limited capacity, and low reimbursement rates while caring for clinically complex and vulnerable patient populations. The letters expressed concern that reinstating the productivity adjustment could further strain access to care, staffing, and financial stability for providers that play a critical role in Maryland's healthcare system.

## 8. Discontinue the Productivity Adjustment for Non-GBR Hospitals

### *HSCRC Response:*

*Staff followed the formulaic approach in the development of the draft recommendation by applying the productivity adjustment of -0.80% is in line with the proposed IPPS rule for FFY 27. The productivity adjustment is a tool that aligns Medicare payment updates with broader economic productivity trends, promoting cost control and efficiency in hospital operations. A productivity adjustment is applied to hospitals under both IPPS and IPF PPS. HSCRC staff do not set Medicare rates for non-GBR hospitals. The proposed update is included for non-governmental payers. HSCRC staff understand that non-GBR hospitals are facing similar cost pressures to GBR hospitals. Volumes at these hospitals are still down relative to a 2019 base and as these volumes declined they were removed based on a 100 percent variable cost factor. These hospitals are a valuable resource in the Maryland healthcare ecosystem. It is important that they have the ability to respond to the needs of the community and be available as a statewide resource in specialty hospital care for pediatrics and psychiatric services.*

*Staff agrees to waive the productivity adjustment for RY 2027. Staff also believe that moving forward exploration of productivity adjustment alternatives should be considered.*

# Update Factor Discussion

**Table 2: Update  
Factor Schedule**

Balanced Update Model for RY 2027				
<u>Components of Revenue Change Link to Hospital Cost Drivers /Performance</u>				
		Weighted Allowance	All Payer Revenue Increase (Millions)	Medicare Revenue Increase (Millions)
<b>Adjustment for Inflation (this includes 3.10% for Wages and Salaries)</b>		3.11%	\$746.5	\$246.3
- Additional Inflation Support		0.20%	\$48.1	\$15.9
- Outpatient Oncology Drugs		0.06%	\$15.2	\$5.0
<b>Gross Inflation Allowance</b>	<b>A</b>	<b>3.37%</b>	<b>\$809.8</b>	<b>\$267.2</b>
<b>Care Coordination/Population Health</b>				
- Reversal of One-Time Grants		-0.15%	-\$36.9	-\$12.2
- Grant Funding RY27		0.02%	\$3.7	\$1.2
- HOPE		0.21%	\$50.0	\$16.5
- CTI Transition		0.20%	\$48.7	\$16.1
<b>Total Care Coordination/Population Health</b>	<b>B</b>	<b>0.27%</b>	<b>\$65.5</b>	<b>\$21.6</b>
<b>Adjustment for Volume</b>				
- Demographic /Population Standard Policy		0.12%	\$28.8	\$9.5
- Demographic Policy Refinement - RY2026 Incremental Change		0.03%	\$7.9	\$2.6
<b>Total Adjustment for Volume</b>	<b>C</b>	<b>0.15%</b>	<b>\$36.7</b>	<b>\$12.1</b>
<b>Financial Methodologies &amp; Other Adjustments (positive and negative)</b>				
- Set Aside for Unknown Adjustments	D	0.40%	\$96.1	\$31.7
- Low Efficiency Outliers/Revenue for Reform	E	0.00%	\$0.0	\$0.0
- Complexity & Innovation	F	0.16%	\$37.5	\$12.4
- Full Rate Application & Capital Funding	G	0.07%	\$16.2	\$5.3
- Reversal of one-time adjustments for drugs	H	-0.06%	-\$14.7	-\$4.9
- Reversal of Surge Funding (RY24-RY25 in RY26 rates)	I	-0.81%	-\$194.3	-\$64.1
- RY26 Respiratory Surge Funding Estimate (9 month)	J	0.19%	\$44.7	\$14.7
- RY25 New Volume Policies	K	0.06%	\$14.7	\$4.8
<b>Net Other Adjustments</b>	<b>L = Sum of D thru K</b>	<b>0.00%</b>	<b>\$0.1</b>	<b>\$0.0</b>
<b>Quality and PAU Savings</b>				
- PAU Redistribution	M	-0.02%	-\$5.5	-\$1.8
- Reversal of prior year quality incentives	N	0.04%	\$9.7	\$3.2
- Current Year Quality Incentives	O	-0.06%	-\$15.0	-\$5.0
<b>Net Quality and PAU Savings</b>	<b>P= Sum of M thru O</b>	<b>-0.04%</b>	<b>-\$10.7</b>	<b>-\$3.5</b>
<b>Total Update First Half of Rate Year</b>	<b>Q= Sum of A+B+C+L+P</b>	<b>3.75%</b>	<b>\$901.4</b>	<b>\$297.5</b>
	<b>R= (1+Q)/(1+0.12%)</b>	<b>3.63%</b>		
<u>Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements</u>				
- Uncompensated care, net of differential	S	0.52%	\$125.0	\$41.2
- Deficit Assessment	T	-0.20%	-\$47.6	-\$15.7
	<b>U= Sum of S thru T</b>	<b>0.32%</b>	<b>\$77.3</b>	<b>\$25.5</b>
<b>Total Update First Half of Rate Year 27</b>	<b>V= Q+U</b>	<b>4.07%</b>	<b>\$978.8</b>	<b>\$323.0</b>
Revenue growth, net of offsets	<b>W= (1+V)/(1+0.12%)</b>	<b>3.95%</b>		
Per Capita Revenue Growth				
<b>Adjustments in Second Half of Rate Year</b>				
- Medicare Advantage Stabilization*		0.00%	\$0.0	\$0.0
<b>Total Adjustments Second Half of Rate Year</b>	<b>X</b>	<b>0.00%</b>	<b>\$0.0</b>	<b>\$0.0</b>
<b>Total Update Full Rate Year</b>	<b>Y V+X</b>	<b>4.07%</b>	<b>\$978.8</b>	<b>\$323.0</b>
	<b>Z (1+Y)/(1+0.12%)</b>	<b>3.95%</b>		

\*MA Stabilization has a revenue neutral impact on proposed increase to revenues, staff are adding this for awareness due to the adjustment being new in CY27.

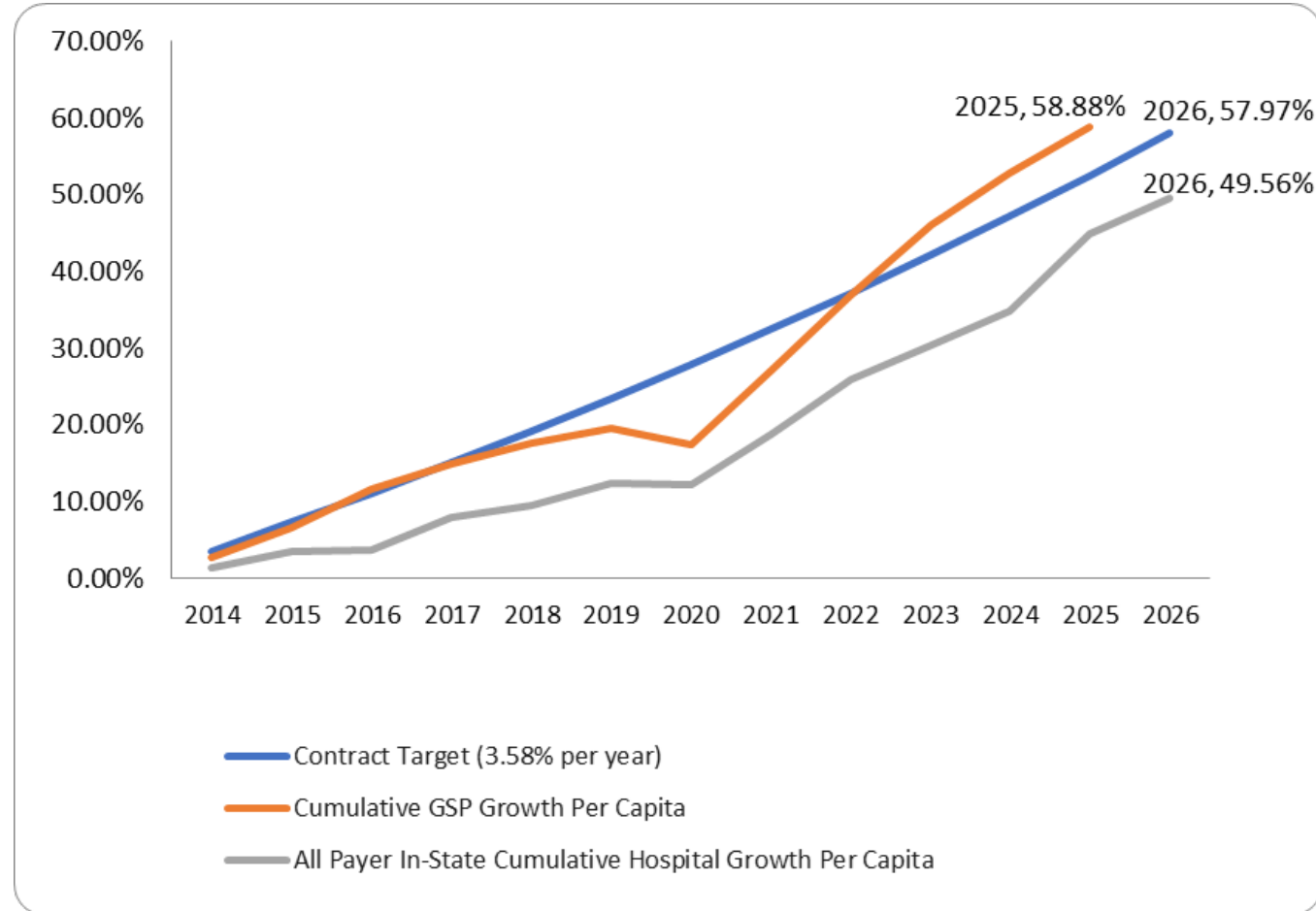
# Revenue Scenarios

**Table 5: CY 2026 Global Budget Revenue Estimate**

<b>Estimated Position on Medicare Test (in billions)</b>		
Actual Revenue January - June 2025		11,469,777
Actual Revenue July - December 2025		11,856,401
Actual Revenue CY 2025		23,326,178
<b>Step 1:</b>		
Approved GBR RY 2026		24,029,465
Actual Revenue 7/1/25-12/31/25		11,856,401
Approved Revenue 1/1/26-6/30/26		12,173,064
Projected FY25 GBR Compliance		0
Anticipated Revenue 1/1/26-6/30/26	<b>A</b>	<b>12,173,064</b>
Expected Revenue Growth 1/1/26-6/30/26		<b>6.13%</b>
<b>Step 2:</b>		
Final Approved GBR RY 2026		24,029,465
Reversal of Material Non-Repeating One-Times		-92,257
Final Adjusted GBR Base for RY 2026		23,937,208
Projected Approved GBR RY 2027		24,912,218
Permanent Update RY 2027		4.07%
<b>Step 3:</b>		
Estimated Revenue 7/1/26-12/31/26 (after 49.73% & seasonality)	<b>B</b>	<b>12,388,846</b>
Expected Revenue Growth 7/1/26- 12/31/26		<b>4.49%</b>
<b>Step 4:</b>		
<b>Estimated Revenue CY 2026</b>	<b>A+B</b>	<b>24,561,910</b>
Increase over CY 2025 Revenue		<b>5.30%</b>
Per Capita Increase over CY 2025		<b>5.17%</b>

# All Payer Test Graphic

Figure 2: Affordability Scorecard – Cumulative GSP Test with CY 2026 Projection



# Medicare FFS TCOC Target

**Target =**

$$\text{Baseline} \times (1 + \text{Interim Years Trend}) \times (1 + \text{National MC FFS Trend} + \text{True Up}) - \text{Savings Component}$$

Final target is risk adjusted using HCC

Baseline = 2023 PBPY amount in State Agreement

Interim Years Trend = Observed USPCC Trend for 2024 and 2025

National MC FFS Trend =  $(1 + \text{Projected USPCC Trend for the current year}) \times (1 + \text{Average of Projected and Observed USPCC Trend for the prior performance year}) \times (1 + \text{Observed USPCC Trend for previous performance years})$

*33% of trends is calculated against national \$ and added to MD \$ instead of applying trend to MD Base \$*

True Up = 50% of projected USPCC misses > .5% in the current year

Savings Component = % in State Agreement

# USPCC At-a-Glance

## General Background

- USPCC projects national per capita fee-for-service (FFS) spending based on CMS' most recent Medicare FFS data, mainly for the purposes of setting MA benchmarks
- Includes FFS spending on all Part A and Part B services (except hospice services and kidney acquisition costs, which are not covered by MA plans) as well as all shared savings and losses paid to FFS providers through the Medicare Shared Savings Program, Innovation Center models, and demonstration programs.
- Medicare determined that it was making duplicative payments for MA-related IME and DGME costs (one payment directly to inpatient facilities, and one payment to MA plans through higher benchmarks), so in 2024, CMS began a three-year removal of MA-related IME and DGME spending from the non-ESRD FFS USPCCs.

## Relevance to AHEAD

AHEAD uses USPCC projections (unlike TCOC Model)

- AHEAD's savings baseline in 2023
- Removing IME between 2024 and 2026 will result in relatively lower USPCC updates over these years
- A change is anticipated but exact method is still TBD

### Resources:

<https://www.cms.gov/files/document/2027-announcement.pdf> See Table II-2 Current Year values

[https://www.medpac.gov/wp-content/uploads/2025/02/02102025\\_MA\\_PD-AN-CY-2026\\_MedPAC\\_COMMENT\\_v2\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2025/02/02102025_MA_PD-AN-CY-2026_MedPAC_COMMENT_v2_SEC.pdf)

<https://www.cms.gov/files/document/2025-announcement.pdf> See page 37

<https://www.commonwealthfund.org/publications/explainer/2024/mar/how-government-updates-payment-rates-medicare-advantage-plans>

# Medicare FFS Savings Tests - Proposed Scenarios

- All scenarios uses HSCRC revenue projection for Part A and Part B MD Hospital
- For MD Non-Hospital and US Hospital and Non-Hospital

**Scenario 1:** 2025 Trended forward at USPCCC Year-1 Trend

**Scenario 2:** 2025 Trended forward at USPCCC Year-1 Trend with IME adjustment

- Amounts shown on following slides include \$ savings estimates, actual contract performance will be stated in trend terms.
- Savings amounts should be considered against a target savings of 0.13% or ~\$16 M.
- All amounts are still in process.
  - 2025 values are not complete, particularly some non-claims-based payments
  - Discussions with CMMI on AHEAD scorekeeping specifics are ongoing

# Scenario 1: 2025 Trended forward at USPCC Year-1 Trend

Scenario 1 Guardrail Projections			
	Maryland	Target (includes savings)	Impact
YOY Growth	5.2%	4.0%	
Cumulative Growth (2023 to 2026)	19.6%	18.7%	-0.9%
Estimated CY 2026 Savings Run Rate			-\$88.7 M dissavings

## Scenario 2: 2025 Trended forward at USPCCC Year-1 Trend with IME adjustment to 2024 to 2026

Scenario 2 Guardrail Projections			
	Maryland	Target (includes savings)	Impact
YOY Growth	5.2%	5.3%	
Cumulative Growth (2023 to 2026)	19.6%	21.8%	+2.2%
Estimated CY 2026 Savings Run Rate			\$260.8 M savings

\*Includes cumulative impact of IME correction, not just 2026 impact.

# Points of Discussion with CMMI

## Still Confirming:

- Actuals under AHEAD calculation methodology
- Specifics of target calculation, including HCC scores for 2026 (uses v28)
  - Currently using 2025 HCC scores as a placeholder
- Timeline for finalization of USPCC values and final savings amount
- Components of and recent changes to USPCC
  - CMMI indicated they would adjust for IME change, but method remains TBD.

# Final Recommendations

## For Global Revenues:

- (a) Provide all hospitals with a gross inflationary increase of 3.37 percent, including an additional 0.20 percent to support revenue needs based on historical underfunding of inflation, and 0.06 percent allocated based on each hospital's proportion of drug costs.
- (b) Provide an overall increase of 4.07 percent for revenue (including a net increase to uncompensated care) and 3.95 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets: a mid-year target and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target, and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.
- (c) **DRAFT RECOMMENDATION:** Provide additional funding related to uncompensated care to the Maryland Health Benefit Exchange Fund of 0.4 percent to support reinsurance and subsidies for marketplace enrollees and 0.1 percent to increase the reserve held in the HSCRC's Uncompensated Care Fund to be released as additional uncompensated care emerges. This element is a draft recommendation and will the 0.5 percent will be removed from the update factor if the final recommendation is not approved subsequently.

## For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- (a) Provide an overall update of 3.17 percent for inflation and additional inflation of 0.20, for a total update of 3.37 percent. Suspend the productivity adjustment for RY 2027.



# Final Recommendation for the Update Factors for Rate Year 2027

This represents the Final Recommendation for RY 2027 except Recommendation item (c) which is draft (outlined on page 3 and 35).

Comments on this element should be submitted to [hsrc.payment@maryland.gov](mailto:hsrc.payment@maryland.gov) by June 24, 2026.

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## List of Abbreviations

AHEAD	Achieving Healthcare Efficiency through Accountable Design
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for our Patients
CY	Calendar year
DSH	Disproportionate Share Hospital
FFS	Fee-for-service
FY	Fiscal Year
FFY	Federal fiscal year refers to the period of October 1 through September 30
GBR	Global Budget Revenue
GSP	Gross State Product
HSCRC	Health Services Cost Review Commission
ICC	Interhospital Cost Comparison
MHAC	Maryland Hospital Acquired Conditions
PAU	Potentially avoidable utilization
QBR	Quality-Based Reimbursement
RRIP	Readmission Reduction Incentive Program
RY	Rate year, which is July 1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care
USPCC	United States Per Capita Cost

## Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
<p>The annual update factor is intended to provide hospitals with reasonable changes to rates in order to maintain operational readiness while also seeking to contain the growth of hospital costs in the State. In addition, the policy aims to be fair and reasonable for hospitals and payers.</p>	<p>The final recommendation provides an annual update factor of 3.95 percent per capita, a revenue increase of 4.07 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 3.37 percent for hospitals not under Global Budgets, which includes psychiatric hospitals and Mt. Washington Pediatrics.</p>	<p>The annual update factor provides hospitals with permanent and one-time adjustments to their respective rate orders for RY 2027. The update includes changes for inflation, high-cost drugs, care coordination, complexity and innovation, quality, respiratory surge, uncompensated care, and others as deemed necessary.</p>	<p>One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the AHEAD Model. Applied to all payers in the system, the update factor determination ensures that the increases to hospital rates borne by all purchasers of hospital services, including consumers, is reasonable and affordable.</p>	<p>The annual update factor contains the growth of costs for all payers and reflects ongoing investments in population health and health equity. The update factor also reflects quality measures, including within-hospital disparities, that aim to improve health disparities across the State.</p>

## Executive Summary

The following report includes a final recommendation for the Update Factor for Rate Year (RY) 2027. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness and to keep healthcare affordable in the State of Maryland.

This recommendation generally follows approaches established in prior years for setting the update factors. As with all HSCRC policies, the aim is equity and fairness for all hospitals and payers that balances the need to provide sufficient resources for operational readiness and necessary investment, while simultaneously ensuring affordability for consumers and purchasers of hospital services, as well as meeting all of the State’s contractual obligations with the federal government.

Staff requests that Commissioners consider the following final recommendations:

For Global Revenues:

- (a) Provide all hospitals with a gross inflationary increase of 3.37 percent, including an additional 0.20 percent to support revenue needs based on historical underfunding of inflation, and 0.06 percent allocated based on each hospital's proportion of drug costs.
- (b) Provide an overall increase of 4.07 percent for revenue (including a net increase to uncompensated care) and 3.95 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets: a mid-year target and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target, and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.
- (c) Provide additional funding related to uncompensated care to the Maryland Health Benefit Exchange Fund of 0.4 percent to support reinsurance and subsidies for marketplace enrollees and 0.1 percent to increase the reserve held in the HSCRC's Uncompensated Care Fund to be released as additional uncompensated care emerges. This element is a draft recommendation and will be removed from the update factor if the final recommendation is not approved subsequently.

For Non-Global Revenues, including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- (a) Provide an overall update of 3.17 percent for inflation and additional inflation of 0.20, for a total update of 3.37 percent. Suspend the productivity adjustment for RY 2027.

## **Introduction & Background**

The Maryland Health Services Cost Review Commission (HSCRC or Commission) updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy-related adjustments, other adjustments related to performance, and settlements from the prior year. For this upcoming fiscal year in the development of the update factor, the HSCRC is considering the impact recent inflationary trends have had on the healthcare industry. As in all the HSCRC policies, this recommendation strives to achieve a fair and equitable balance between providing sufficient funds to cover operational expenses and necessary investments, while keeping the increase in hospital costs affordable for all payers.

On November 12, 2025, CMS and Maryland signed the Amended and Restated Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model Maryland State Agreement (AHEAD Model), replacing the prior AHEAD Agreement signed in 2024. The AHEAD Model will test whether a flexible framework that includes statewide accountability targets for all-payer and Medicare Fee-For-Service (FFS) cost growth, primary care investment, and population health outcomes results in improved population health and healthier living, enhanced quality outcomes, and lowered growth of health care costs. Under the Amended and Restated AHEAD Model Maryland State Agreement, the Maryland AHEAD Implementation Period officially began on January 1, 2026. Under AHEAD, Maryland must meet Medicare FFS TCOC savings targets, all-payer TCOC growth targets, and a hospital all-payer revenue limit. HSCRC will need to closely monitor state-wide hospital revenue growth in order to meet these tests.

The approach to developing the RY 2027 annual update is outlined in this report, as well as staff's estimates on calendar year AHEAD Model tests. There are two categories of hospital revenue types included in this recommendation:

1. Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority. The proposed update factor for hospitals under Global Budget Revenues is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per capita growth rates, rather than unit rate changes.
2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland, and, thus, Medicare does not pay based on those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital. The proposed update factor for these hospitals only affects the hospital's price, not volume.

This recommendation proposes Rate Year (RY) 2027 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

### **Overview of Final Update Factors Recommendations**

For RY 2027, HSCRC staff is proposing an update of 3.95 percent per capita for global budget revenues and an update of 3.37 percent for non-global budget revenues. These figures are described in more detail below.

### **Calculation of the Inflation/Trend Adjustment**

The publication schedule for S&P Global (Global Insights) has been revised, resulting in a one-quarter delay in the release of quarterly reports relative to prior practice. As a result, the First Quarter publication, previously used to inform staff evaluations and final recommendations, will no longer be available within the required timeframe. As a result of this publication change, staff will

transition to using the Fourth Quarter publication as the basis for Update Factor calculations going forward.

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC’s calculation of the update adjustment. The inflation calculation blends the weighted market basket growth estimate with a capital growth estimate using the Quarter 2 projection for 2027 from the Fourth Quarter book for 2025. For RY 2027, HSCRC Staff combined 91.20 percent market basket growth of 3.20 percent with 8.80 percent of the capital growth estimate of 2.90 percent, calculating the gross blended amount as a 3.17 percent inflation adjustment.

**Update Factor Final Recommendation for Non-Global Budget Revenue Hospitals**

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC staff proposes applying the inflation adjustment of 3.17 percent with an additional 0.20 percent for additional inflation support. Staff recommends suspending the productivity adjustment of 0.80 percent. The resulting proposed net update is approximately 3.37 percent.

**Table 1: Base Inflation Inputs**

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.17%	3.17%
Productivity Adjustment	N/A	SUSPEND
Additional Inflation Support	0.20%	0.20%
Proposed Inflation Update	3.37%	3.37%

**Update Factor Recommendation for Global Budget Revenue Hospitals**

In considering the system-wide update for the hospitals with global revenue budgets under the AHEAD Model, HSCRC staff sought to achieve balance among the following conditions:

- Meeting the requirements of the AHEAD Model, including achieving the Medicare Total Cost of Care savings targets, which increase according to a preset schedule relative to a calendar year 2023 base, beginning in CY 2026. The amount required increases throughout the agreement; for 2026, it is 0.13 percent.
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes.

- Ensuring that hospitals have adequate resources to invest in care coordination and population health strategies necessary for long-term success under the AHEAD Model as well as a framework for doing so;
- Incorporating quality performance programs.
- Ensuring that healthcare remains affordable for all Marylanders.

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates revenue growth for the full rate year to be 4.07 percent with a corresponding per capita growth rate of 3.95 percent. The 4.07 percent revenue growth will be used to measure the proposed update against financial tests, which are performed on Calendar Year results; staff split the annual Rate Year revenue into six-month targets. Staff intends to apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2027 estimated revenue used to evaluate the Rate Year year-end target. HSCRC staff will adjust the revenue split to accommodate their normal seasonality for hospitals that do not align with the traditional seasonality described above.

### **Net Impact of Adjustments**

Table 2 summarizes the net impact of the HSCRC Staff's final recommendation for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments to global revenues. Descriptions of each step and the associated policy considerations are explained in the text following the table.

**Table 2: Update Factor Schedule**

<b>Balanced Update Model for RY 2027</b>				
<u>Components of Revenue Change Link to Hospital Cost Drivers /Performance</u>				
		Weighted Allowance	All Payer Revenue Increase (Millions)	Medicare Revenue Increase (Millions)
<b>Adjustment for Inflation (this includes 3.10% for Wages and Salaries)</b>				
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- Outpatient Oncology Drugs		0.20%	\$48.1	\$15.9
		0.06%	\$15.2	\$5.0
<b>Gross Inflation Allowance</b>	<b>A</b>	<b>3.37%</b>	<b>\$809.8</b>	<b>\$267.2</b>
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- HOPE		0.21%	\$50.0	\$16.5
- CTI Transition		0.20%	\$48.7	\$16.1
<b>Total Care Coordination/Population Health</b>	<b>B</b>	<b>0.27%</b>	<b>\$65.5</b>	<b>\$21.6</b>
<b>Adjustment for Volume</b>				
- Demographic /Population Standard Policy		0.12%	\$28.8	\$9.5
- Demographic Policy Refinement - RY2026 Incremental Change		0.03%	\$7.9	\$2.6
<b>Total Adjustment for Volume</b>	<b>C</b>	<b>0.15%</b>	<b>\$36.7</b>	<b>\$12.1</b>
<b>Financial Methodologies &amp; Other Adjustments (positive and negative)</b>				
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- Complexity & Innovation	F	0.16%	\$37.5	\$12.4
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- RY26 Respiratory Surge Funding Estimate (9 month)	J	0.19%	\$44.7	\$14.7
- RY25 New Volume Policies	K	0.06%	\$14.7	\$4.8
<b>Net Other Adjustments</b>	<b>L = Sum of D thru K</b>	<b>0.00%</b>	<b>\$0.1</b>	<b>\$0.0</b>
<b>Quality and PAU Savings</b>				
- PAU Redistribution	M	-0.02%	-\$5.5	-\$1.8
- Reversal of prior year quality incentives	N	0.04%	\$9.7	\$3.2
- Current Year Quality Incentives	O	-0.06%	-\$15.0	-\$5.0
<b>Net Quality and PAU Savings</b>	<b>P= Sum of M thru O</b>	<b>-0.04%</b>	<b>-\$10.7</b>	<b>-\$3.5</b>
<b>Total Update First Half of Rate Year</b>				
	<b>Q=</b>	<b>Sum of A + B + C + L + P</b>	<b>3.75%</b>	<b>\$901.4</b>
	<b>R=</b>	<b>(1-Q)/(1+0.12%)</b>	<b>3.63%</b>	
<u>Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements</u>				
- Uncompensated care, net of differential	S	0.52%	\$125.0	\$41.2
- Deficit Assessment	T	-0.20%	-\$47.6	-\$15.7
	<b>U=</b>	<b>Sum of S thru T</b>	<b>0.32%</b>	<b>\$77.3</b>
<b>Total Update First Half of Rate Year 27</b>				
Revenue growth, net of offsets	<b>V=</b>	<b>Q+U</b>	<b>4.07%</b>	<b>\$978.8</b>
Per Capita Revenue Growth	<b>W=</b>	<b>(1+V)/(1+0.12%)</b>	<b>3.95%</b>	<b>\$323.0</b>
<b>Adjustments in Second Half of Rate Year</b>				
- Medicare Advantage Stabilization*		0.00%	\$0.0	\$0.0
<b>Total Adjustments Second Half of Rate Year</b>	<b>X</b>	<b>0.00%</b>	<b>\$0.0</b>	<b>\$0.0</b>
<b>Total Update Full Rate Year</b>				
	<b>Y</b>	<b>V+X</b>	<b>4.07%</b>	<b>\$978.8</b>
	<b>Z</b>	<b>(1+Y)/(1+0.12%)</b>	<b>3.95%</b>	<b>\$323.0</b>

\*MA Stabilization has a revenue neutral impact on proposed increase to revenues, staff are adding this for awareness due to the adjustment being new in CY27.

## Central Components of Revenue Change Linked to Hospital Cost Drivers/Performance

HSCRC staff accounted for several factors that are central provisions to the update process and are linked to hospital costs and performance. These include:

- Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 3.17 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight’s Fourth Quarter 2025 market basket growth of 3.20 percent, with 8.80 percent of the capital growth index change of 2.90 percent. The adjustment for inflation includes 3.30 percent for wages and compensation.

In RY 2025, staff implemented a catch-up methodology incorporating a two-sided risk corridor of 1.00 percent to evaluate cumulative over- or underfunding. This methodology was subsequently refined in RY 2026, reducing the corridor to 0.25 percent. Under the revised framework, the Commission will adjust future inflation only when the variance between actual and funded inflation exceeds 0.25 percent. Variances within this range do not warrant adjustment, as such levels have historically been considered acceptable. Through RY 2025, the cumulative underfunding of inflation is 0.45 percent (as illustrated in Table 3), an amount that exceeds the 0.25 percent guardrail. The RY 2026 period has not been included in this review, as it still requires 4 more quarters of data to be deemed complete. As a result, the staff has applied the variance of 0.20 percent as an additional inflation allowance for RY 2027.

**Table 3: Inflation Risk Corridor Methodology**

Fiscal Year	Historical												Incomplete		Projected			
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	
HSCRC Funded Inflation	1.65%	2.40%	2.40%	1.92%	2.68%	2.32%	2.96%	2.77%	2.57%	4.06%	3.35%	3.24%	3.36%	3.17%	3.17%	3.17%	3.17%	
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%	3.71%	3.44%	3.08%	3.17%	3.17%	3.17%	3.17%	
Actual Inflation Correction as approved by Commission												1.00%	0.27%	0.20%	0.00%	0.00%	0.00%	
(Under)/Over Funding	-0.10%	0.55%	0.73%	-0.36%	0.20%	-0.08%	0.64%	0.39%	-2.12%	-0.98%	-0.35%	0.80%	0.54%	0.20%	0.00%	0.00%	0.00%	
Cumulative Difference (2014 Base)	-0.10%	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	-0.19%	-1.17%	-1.51%	-0.72%	-0.18%	0.02%	0.02%	0.02%	0.02%	
Guardrail/Tolerance (A)											1.00%	1.00%	0.25%	0.25%	0.25%	0.25%	0.25%	
Cumulative Difference with Anticipated Inflation Correction (2014 Base) (B)	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	-0.19%	-1.17%	-0.52%	-0.45%	0.02%	0.02%	0.02%	0.02%	0.02%	
Calculated Inflation Correction (C) = (A+1)/(B+1)-1										1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
HSCRC Funded Inflation with Actual Inflation Correction											3.35%	4.24%	3.63%	3.37%	3.17%	3.17%	3.17%	

- **Outpatient Oncology and Infusion Drugs:** The rising cost of drugs, particularly of new physician-administered oncology and infusion drugs in the outpatient setting, led to the creation of separate inflation and volume adjustments for these drugs. Not all hospitals provide these services, and some hospitals have a much larger proportion of costs allocated. To address this situation, in Rate Year 2016, staff began allocating a specific part of the inflation adjustment to funding increases in the cost of drugs, based on the portion of each hospital's total costs that comprised these types of drugs.

In addition to the drug inflation allowance, the HSCRC provides a utilization adjustment for these drugs.

At the January 8, 2025 Commission meeting, the Commission voted to approve revisions to the outpatient high-cost drug funding policy, or CDS-A policy. The approved revision included providing funding based on 100 percent reimbursement of changes in drug cost. As a result of this policy revision, inflation is only needed for pure price, which is the price change of each drug at its base year volume. For the RY 2027 Update Factor, staff are using a 3 percent inflation assumption based on longer term trends of pure price. This value remains the same for both academic and non-academic hospitals. The result of this translates to approximately a 0.06 percent carve out of inflation.

- **Care Coordination / Population Health:** In RY 2026, several grant programs focused on Care Coordination and Population Health were implemented, which contributed to hospital revenues. These programs included the Behavioral Health Funding and New Paradigms in Care Delivery. The funds were allocated to hospitals on a one-time basis. As a result, Table 2 reflects a reversal of grant funding for RY 2026 at a rate of -0.15 percent. RY 2026 marked the conclusion of the Regional Partnership Grants. For RY 2027, a small carryover for New Paradigm funding will be implemented into rates.

The Healthcare Outcomes Payment Effort (HOPE) replaces Care Transformation Initiatives (CTIs) which Health Services Cost Review Commission (HSCRC) staff are proposing to sunset. The objective of HOPE is to create a clear, predictable, and accountable payment structure that enables hospitals and community partners to invest in interventions and share in savings. HOPE seeks to sustain and expand population health investments that advance Achieving Healthcare Efficiency through Accountable Design's (AHEAD) goals and drive meaningful system transformation.

HOPE is a voluntary, upside-only, shared savings, outcome payment model whereby proposals will be reviewed and approved by a committee of experts. One path to participation is for hospitals, alone or with partners, and the other path is for regional or statewide initiatives. Outcome payments will be initially anticipated to be \$50 million each year, included in the annual update factor, with the commission only able to qualify interventions with up to \$100 million in possible outcome payments, recognizing that initiatives may not be successful in reducing costs. Hospitals and Statewide and Regional

Initiative partners receive 50 percent of measured savings, ensuring aligned incentives across participating entities. Payments will be made regardless of position on the Medicare savings test or other affordability tests. Funding for Regional and Statewide initiatives funding are individually approved by the Commission and will not count towards the \$50 million.

HSCRC anticipates final authorization for HOPE in June 2026 as part of the RY27 update factor final recommendation. If HOPE does not pass in the June 2026 recommendation, it will be removed from the RY27 update factor.

CTI Transition funding was included as part of the final recommendation. These dollars will be provided based on system level earnings that would have been paid out as part of the CTI rewards in RY2027 for the RY2025 performance year. This funding is one-time funding. An amount of \$48.7 million is included but the final payout will be based on the final reporting which is not yet available but is expected not to materially differ from the amount used in this final recommendation.

Collectively, these adjustments result in a net increase of 0.27 percent for Care Coordination and Population Health.

- **Adjustments for Volume:** The demographic adjustment policy is an annual prospective update to Maryland hospitals' global budget that accounts for age-adjusted population volume changes within a hospital's service area. Staff proposes a 0.12 percent population growth estimate for RY 2027 and a refined 0.77 percent for RY 2026, both of which incorporate specific Commission-approved adjustments.

To prevent double payment, staff exclude revenue already covered by distinct volume policies—specifically out-of-state volumes, high-cost drugs (CDS-A), and to some extent quaternary services through the complexity & Innovation policy. Additionally, a 0.1 percent national demand modifier is applied to align Maryland's growth with national per capita utilization trends. For RY 2026, these adjustments account for a 0.03 percent increase over the standard methodology, as detailed in Table 2.

Historically, the Demographic Adjustment reconciled to the percentage growth statistic reported by the Department of Planning, rather than the actual population count. Because hospitals vary in size, this approach resulted in allocations that did not align precisely with the actual population change. To address both the revised Planning estimates and the limitations of reconciling to a percentage growth rate, staff reconciled to the cumulative population count from 2020 through the most recent year.

- **Set-Aside:** The intention of the set-aside is to use these funds for 1) Global Budget Revenue enhancements for relatively efficient hospitals that qualify under the Integrated Efficiency policy and 2) unforeseen events that occur at hospitals with financial hardship,

regardless of efficiency (e.g., cyberattacks). Staff is recommending 0.40 percent for RY 2027.

- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining relatively inefficient hospitals in the TCOC Model. The policy utilizes the Inter-Hospital Cost Comparison (ICC) methodology to compare relative cost-per-case efficiency and Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used in an ordinal ranking scoring matrix to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals or potentially for reinvestment through the proposed Revenue for Reform policy.

For purposes of the Update Factor inputs, staff has earmarked a 0 percent reduction for low efficiency outliers, because relatively inefficient hospitals are encouraged to buyout of their reductions through investments in Revenue for Reform, and if buyouts do not occur, relatively efficient hospitals can petition the Commission for funding that is withheld from relatively inefficient hospitals.

- **Complexity and Innovation (formerly Categorical Cases):** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as CAR-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, HSCRC staff developed an approach to provide a higher variable cost factor (100 percent for drugs and supplies, 50 percent for all other charges) to in-state, inpatient cases when a hospital exhibits dominance in an ICD-10 procedure codes and the case has a casemix index of 1.5 or higher. Staff used this approach to determine the historical average growth rate of cases deemed eligible for the complexity and innovation policy and evaluated the adequacy of funding of these cases relative to prospective adjustments provided to Johns Hopkins Hospital and University of Maryland Medical Center from RY 2017 to RY 2025. Based on this analysis, staff concluded that the historical average growth rate was approximately 0.39 percent, which equates to a combined State impact of 0.16 percent for the RY 2027 Update Factor. Staff are currently evaluating a new approach to funding this type of care via carve out and expect a final recommendation to the Commission in July 2026, should the Commission adopt this approach it may impact this funding.
- **Capital Funding and Estimated Increase for Full Rate Applications:** Preliminary modeling indicates that efficient hospitals may be entitled to approximately \$6 million through the Full Rate Application Policy and Shady Grove will get approximately \$9 million dollars in concert with the opening of their capital project, which represents 0.07 percent of the recommendation. This value is subject to change based on quality assurance reviews

of the Inter-hospital Cost Comparison (ICC) methodology and review of commercial TCOC benchmarks. Hospitals eligible for a rate enhancement through the full rate application policy in RY 2027 can access funding through a streamlined process if the hospital agrees to: the value established by the methodology (no additional methodological considerations will be contemplated); and the hospital will not file any subsequent rate request until July 1, 2028.

- **Surge Allocation:** The Surge Funding value for RY 2027 is 0.19 percent. This amount includes an estimate that has been determined using nine months of Case-mix and Experience data and incorporates the change in weighting to two-thirds evaluation on Case-mix and one-third evaluation on patient days as approved at the January 2026 Commission meeting. This Update Factor recommendation incorporates the reversal of the RY 2024 and RY 2025 surge funding applied in RY 2026, totaling -0.81 percent. The 9-month value will be implemented in July and will then be reconciled with a final 12-month amount in January.
- **New Volume Policies:** In RY 2026, the Commission approved new volume policies not otherwise reflected in existing market shift methodologies. These policies include Deregulation, Repatriation/Expatriation, and Out-of-State (OOS) volume Adjustments. These policies were designed to address shifts in patient utilization occurring outside of traditional in-state regulated market dynamics, including movement to unregulated settings (deregulation), cross-border utilization by Maryland residents (repatriation/expatriation, and changes in utilization at in-state regulated facilities by non-Maryland residents (OOS). For this period, hospitals received adjustments calculated using CY 2024 data. A portion of the adjustments will be implemented in RY 2027, following hospital feedback and additional staff review. These policies have an estimated impact of approximately 0.04 percent in the RY 2027 Update Factor. In addition, at the December 2025 Volume Workgroup meeting, staff introduced a policy update formalizing the treatment of Potentially Avoidable Utilization (PAU) associated with hospital conversions to Freestanding Medical Facilities (FMFs) within the Market Shift Policy. This update ensures consistent treatment of PAU-related volume and avoids overstating growth from FMF conversions. The estimated impact of this adjustment is approximately 0.02 percent. Together, these volume-related changes result in a combined impact of approximately 0.06 percent in the RY 2027 Update Factor.
- **Potentially Avoidable Utilization (PAU) Redistribution:** The PAU value for RY 2027, which represents defunding of inflation and population growth for readmissions and avoidable admissions, is -0.37 percent. This policy was refined in RY 2025 to be revenue-neutral across the State; however, there were concerns that the policy may reward hospitals that have not improved PAU performance under the TCOC Model. As a result of this concern, rewards for individual hospitals are capped at 0.0 percent, and minor negative scaling is still applied to hospitals that have worse PAU performance than the

statewide average. The net result of the PAU Redistribution policy, as represented on Table 2, is -0.02 percent.

- **Quality Scaling Adjustments:** The quality pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP) including the Disparity Gap Incentive, and Quality Based Reimbursement Program (QBR). Preliminary QBR adjustments will be implemented with the July rate orders and adjustments will be made in the January rate orders to reflect the full measurement period. The current revenue adjustments across the three programs is -0.06 percent (with preliminary QBR). The Update Factor recommendation reflects the reversal of the prior year's Quality adjustments of 0.04 percent.

## Central Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements

In addition to the central provisions that are linked to hospital costs and performance, HSCRC staff also considered revenue offsets with a neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2027 will be 0.02 percent. The amount in rates was 4.03 percent in RY 2026, and the proposed amount for RY 2027 is 4.05 percent, an increase of 0.02 percent. The final statewide UCC amount is subject to some variability based on updated December annual filing submissions and UCC Fund reserve levels.

Staff considered whether federal changes to coverage policy warrants a prospective adjustment to uncompensated care. Staff do not anticipate that short-term increases for the Medicaid population are likely to be significant, because of: 1) the timeline for the new requirements (*i.e.*, six-month redeterminations and work requirements); 2) the likelihood of Medicaid eligibility determination at the time of the hospital visit (*i.e.*, due to an exemption from work requirements or procedural re-enrollment). Many individuals losing Medicaid coverage due to new immigration requirements will qualify for coverage under Emergency Medicaid Services.

In the individual market, the Maryland Health Benefit Exchange projected coverage losses of 48,000.<sup>1</sup> As of April 2026, the individual market had seen an eight percent decline in year-over-year enrollment, numbering approximately 18,000 individuals.<sup>2</sup>

A 48,000-beneficiary decline in the marketplace correlates to approximately \$117 million in hospital uncompensated care, assuming these enrollees have similar experience to existing uninsured individuals. In addition, working with Medicaid, the HSCRC estimates FY 2027 Medicaid losses to translate into approximately \$11 million of hospital uncompensated care.<sup>3</sup> Based on these estimates, which contain considerable uncertainty, the UCC exposure is \$128 million or approximately 0.50 percent.

To help mitigate these coverage losses and reduce the impact on uncompensated care costs in the hospital market, Staff is proposing to provide 0.40 percent in funding to the Maryland Health Benefit Exchange Fund to provide additional reinsurance and state subsidies for marketplace enrollees and 0.10 percent to increase the reserves held in HSCRC's Uncompensated Care Fund. The Maryland Health Benefit Exchange Fund finances the operations of the Maryland insurance marketplace. Reserves in the HSCRC's Uncompensated Care Fund would be released as additional uncompensated care emerges.

This amount will be allocated across hospitals in proportion to their global budget and hospitals will collect it and remit it to the Maryland Health Benefit Exchange Fund and the HSCRC's Uncompensated Care Fund, as directed by the HSCRC. As this element is newly introduced, Staff are presenting this element as a draft recommendation with a final recommendation to follow in a subsequent Commission meeting. Staff also are considering options for providing funding to FQHCs to expand services to reduce the unnecessary use of hospital services. This is not included in this recommendation due to the complexity required but Staff are interested in comments on whether and how to direct uncompensated care funding to FQHCs, so that uninsured individuals can receive care in the most appropriate setting.

- **Deficit Assessment:** The Legislature approved a funding level of \$394,825,000 for RY 2027. The values associated with this funding level will be applied to payers and are reflected as a -0.20 percent adjustment in Table 2.

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<sup>1</sup> Maryland Health Benefit Exchange. (Aug. 2025). Final 2026 State Subsidy and Reinsurance Parameters. Available <https://www.marylandhbe.com/wp-content/uploads/2025/08/2026-State-Subsidy-and-Reinsurance-Parameters-8-18-25.pdf>; accessed 26 May 2026.

<sup>2</sup> Maryland Health Benefit Exchange. (Apr. 2026). Data Report. Available [https://www.marylandhbe.com/wp-content/uploads/2026/05/Executive-Report\\_-as-of-04302026.pdf](https://www.marylandhbe.com/wp-content/uploads/2026/05/Executive-Report_-as-of-04302026.pdf); accessed 26 May 2026.

<sup>3</sup> Medicaid estimates were derived prior to CMS' release of the Medicaid Community Engagement Requirement for Certain Individuals Interim Final Rule on June 2, 2026.

- Medicare Advantage Stabilization:** Starting in CY 2027, qualifying Medicare Advantage plans will receive rate relief through an increase in the public payer differential. Eight MA contracts, representing six parent companies and over 172,000 Marylanders, have qualified for the rate relief program in CY 2027. The increase will be offset by Medicaid and commercial payers in CY 2027 and commercial payers (only) from CY 2028 onward.

### Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers. These additional variables include one-time adjustments, revenue and rate compliance adjustments, and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

### PAU Redistribution - Updated Methodology

The PAU Savings Policy historically reduces hospital global budget revenues in anticipation of volume reductions due to care transformation efforts. Starting in RY 2020, the calculation of the statewide value of the PAU Savings was included in the Update Factor Recommendation.

For RY 2027, the incremental amount of statewide PAU Savings reductions was determined formulaically by using inflation and the demographic adjustment applied to the amount of PAU revenue (see Table 4). This would result in a RY 2027 permanent PAU savings reduction of -0.37 percent statewide, or -\$83,122,852. Hospital performance on avoidable admissions per capita and 30-day readmissions, the latter of which is attributed to the index hospital, determines each hospital's share of the statewide reduction.

**Table 4: PAU Shared Savings Adjustment**

Statewide PAU Reduction	Formula	Value
RY 2026 Total Approved Permanent Revenue	A	\$22,465,635,668
RY 2027 Inflation Factor+Demographic Adjustment	B	3.29%
CY 2025 Total Experienced PAU \$	C	\$2,554,637,322
Proposed Revenue Adjustment \$	D = B*C	-\$84,047,568
Proposed Revenue Adjustment %	E = D/A	-0.37412%
Adjusted Proposed Revenue Adjustment %	F = ROUND(E)	<b>-0.37000%</b>
Adjusted Proposed Revenue Adjustment \$ * **	G = F*A	<b>-\$83,122,852</b>
Total PAU %	H	11.08%
Total PAU \$	I = A*H	\$2,488,773,634
Required Percent Reduction PAU	J = G/I	-3.34%

\*Does not include revenue from McCready or freestanding EDs.

\*\* Inflation factor is subject to revisions related to updated data and Commission approval

However, as previously noted, staff are proposing to maintain the amendment to the PAU Shared Savings policy such that it is a PAU Redistribution policy, whereby the PAU measurement is utilized in order to recognize differential opportunities among hospitals in a fixed revenue model but does not generate TCOC Model savings. The reasons for this change, which was adopted in RY 2025, are as follows: the policy already generated a 3:1 investment on the Infrastructure Funding that was put into rates to spur improvements in care management, future ongoing reductions may cause access issues, especially for hospitals with low levels of readmissions and avoidable admissions, and the additional funding allows hospitals to make greater investments in population health that overtime will make global budgets more sustainable than annual PAU reductions to hospitals that do not allow for system reinvestment.

The RY 2025 Update Factor recommendation included a requirement for hospitals to submit population health management plans as part of efforts to reduce statewide potentially avoidable utilization, as well as submit high value care plans that described new and existing strategies and initiatives aimed at addressing priority areas of focus identified by the Value-Based Care Insights tool provided by CRISP or an alternate tool. All hospitals completed these requirements and none were subject to a 0.19 percent clawback in their July rate orders.

For RY 2026, hospitals are required to submit final reporting on targets and outcomes for their High Value Care plans by June 1, 2026. All hospitals submitted a report by the deadline, as a result, no hospital will have inflation clawed back in July 2026 rate orders.

For RY 2027, hospitals will be required to report on their improvement targets and outcomes as part of their high value care plans. Failure to report on targets and outcomes will result in a take back of 0.17 percent of inflation removed in the RY 2028 rate orders. Staff anticipate that with this ongoing focus on high value care plans, hospitals will continue to make the reinvestments necessary to improve the health of the population and by extension the financial sustainability of the Model. If the HOPE recommendation is adopted the reporting requirement will be replaced by the HOPE requirement of designating a senior executive responsible for the hospital's population health efforts.

### **Consideration of AHEAD Model Agreement Requirements & National Cost Figures**

As described above, the staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing adjustments for performance under quality programs. Staff's considerations regarding the AHEAD Model agreement requirements are described in detail below.

### **Medicare TCOC Savings Test**

This test under the AHEAD Model requires Maryland to generate 0.13 percent and 0.21 percent in additional Medicare FFS TCOC savings in PY1 (CY 2026) and PY2 (CY 2027), respectively (these amounts are accumulated so the Year 2 target is 0.34 percent). Under current growth

trajectories and beneficiary counts, this is equivalent to Maryland growing an additional \$47 million slower than the national United States Per Capita Cost (USPCC) trend over the two years. AHEAD uses USPCC values to set the Medicare FFS TCOC savings targets, unlike the TCOC Model. USPCC projects national per capita fee-for-service (FFS) spending based on CMS' most recent Medicare FFS data, mainly for the purposes of setting MA benchmarks.<sup>4</sup> As under the TCOC Model, this test ensures that spending increases outside of the hospital setting do not undermine the Medicare hospital savings resulting from any savings produced in the hospital setting. Additionally, the total cost of care focuses hospital efforts and initiatives across the spectrum of care and creates incentives for hospitals to coordinate care and to collaborate outside of their traditional sphere for better patient care.

The Medicare TCOC Savings Target increases annually for the first seven years of the AHEAD Model, culminating in an annual total cost of care savings of 0.63 percent relative to the national growth rate in CY 2032, relative to a 2023 base year.

### **All-Payer Tests**

As under the TCOC Model, the AHEAD Model maintains a 3.58 percent all-payer limit on hospital revenue in the state. However, the AHEAD Model also adds a test requiring the State to establish - and CMS to approve - annual All-Payer TCOC Growth Targets by PY2 (CY 2027). This adds a new CMS element to the HSCRC's existing state mandates related to affordability. The State is currently in the process of establishing this target via a topic-specific advisory group led by the multi-agency Regulatory Working Group, with opportunity for public input. The targets must be formally established under an executive order, legislation, or regulation. Both of these all-payer tests will further inform HSCRC's future update factor process. Additional information can be found on the [HSCRC's AHEAD Model website](#).

### **Meeting Medicare Savings Requirements and Total Cost of Care Guardrails**

Previously, the State was held to a Medicare savings test based on national trends for that year derived from a data set provided by CMS. Staff utilized this claims data and information from CMS' Office of the Actuary to forecast future Medicare trends in order to evaluate the impact of the proposed update factor on the savings test. For the RY2027 update factor, this published estimate will be used to evaluate the update factor impact on the CY2026 savings test. Figure 1 below illustrates the State's understanding of how the Medicare FFS TCOC target will be set.

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<sup>4</sup> USPCC includes FFS spending on all Part A and Part B services (except hospice services and kidney acquisition costs, which are not covered by MA plans and ESRD which is assigned its own trends) as well as all shared savings and losses paid to FFS providers through the Medicare Shared Savings Program, Innovation Center models, and demonstration programs. USPCC trend information can be found here: <https://www.cms.gov/files/document/2027-announcement.pdf> See Table II-2 Current Year values

**Figure 1**  
**AHEAD Savings Target**

$$\text{Target} = \text{Baseline} \times (1 + \text{Interim Years Trend}) \times (1 + \text{National MC FFS Trend} + \text{True Up}) - \text{Savings Component}$$

The **Baseline** is 2023. The **Interim Years Trend** is the adjusted observed USPCC for 2024 and 2025. The **National Medicare FFS Trend** is the product of:

1. The adjusted projected USPCC value availability at the beginning of the Performance Year (PY), or the number released by CMS in the April before the PY (“Year -1”).<sup>5</sup> For 2026, this would be projected USPCC value for 2026, released in April 2025.
2. The average of the projected and observed USPCC for the prior PY<sup>6</sup>, and
3. The observed USPCC for the remaining previous performance years.

Instead of applying trend to the Maryland baseline dollar amount, 33 percent of the **National Medicare FFS Trend** is calculated against the equivalent national dollar amount. The **True Up** adjusts the target by 50 percent of differences between the projected and observed USPCC values beyond .50 percent, the true up only becomes relevant after the performance period when differences between the projected and observed USPCC are known. The **Savings Component** is 0.13 percent and 0.21 percent in additional Medicare FFS TCOC savings in PY1 (CY 2026) and PY2 (CY 2027) mentioned previously.<sup>7</sup> The final target is risk adjusted using HCC scores.

Before evaluating CY2026 results against the Medicare test staff must convert the recommended RY 2027 update to a calendar year growth estimate. Table 5 below shows the current revenue projections for CY 2026 to assist in estimating the impact of the recommended update factor together with the projected RY 2027 results. The overall increase from the bottom of this table is used in Tables 6a-6b.

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<sup>5</sup> CMMI indicated in April 2026 that they want to use Year -1 rather than Year 0 (i.e. USPCC value released in April of the performance year projected numbers to establish in-year targets for each AHEAD PY.

<sup>6</sup> Projected refers to values released in Year 0 and prior and Observed to values released in Year + 1 and subsequent, where Year + 1 refers to the USPCC value released in the year following year 0 (e.g. 2026 values released in 2027).

<sup>7</sup> This number increases between PY1 and PY7 under AHEAD. See Section 10.a.i of the Amended and Restarted Maryland AHEAD State Agreement.

**Table 5: CY 2026 Global Budget Revenue Estimate**

<b>Estimated Position on Medicare Test (in billions)</b>		
Actual Revenue January - June 2025		11,469,777
Actual Revenue July - December 2025		11,856,401
Actual Revenue CY 2025		23,326,178
<b>Step 1:</b>		
Approved GBR RY 2026		24,029,465
Actual Revenue 7/1/25-12/31/25		11,856,401
Approved Revenue 1/1/26-6/30/26		12,173,064
Projected FY25 GBR Compliance		0
Anticipated Revenue 1/1/26-6/30/26	<b>A</b>	<b>12,173,064</b>
Expected Revenue Growth 1/1/26-6/30/26		<b>6.13%</b>
<b>Step 2:</b>		
Final Approved GBR RY 2026		24,029,465
Reversal of Material Non-Repeating One-Times		-92,257
Final Adjusted GBR Base for RY 2026		23,937,208
Projected Approved GBR RY 2027		24,912,218
Permanent Update RY 2027		4.07%
<b>Step 3:</b>		
Estimated Revenue 7/1/26-12/31/26 (after 49.73% & seasonality)	<b>B</b>	<b>12,388,846</b>
Expected Revenue Growth 7/1/26- 12/31/26		<b>4.49%</b>
<b>Step 4:</b>		
<b>Estimated Revenue CY 2026</b>	<b>A+B</b>	<b>24,561,910</b>
Increase over CY 2025 Revenue		<b>5.30%</b>
Per Capita Increase over CY 2025		<b>5.17%</b>

Steps to explain Table 5 are described as below:

The table begins with actual revenue for CY 2025.

**Step 1:** The table uses global revenue for RY 2026 and actual revenue for the last six months for CY 2025 to calculate the projected revenue for the first six months of CY 2026 (i.e., the last six months of RY 2026). Hospitals currently project they will be able to charge all of RY 2026 revenue, for this reason, staff have kept the projected RY 2026 compliance line at zero.

**Step 2:** The final approved GBR for RY 2026 is \$24,029,464,776. This step applies the proposed update of 3.65 percent, as shown in Table 2, to the RY 2026 GBR amount to calculate the projected revenue for RY 2027. This step also makes adjustments for material non-repeating one-times that don't get included in inflation but are accounted for in RY 2026. For RY 2026, this includes one-time funding for the population health trust fund and the FY21-FY23 UCC correction.

**Step 3:** For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2026 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2027.

**Step 4:** This step shows the resulting estimated revenue for CY 2026 and then calculates the increase over the actual CY 2025 Revenue. The CY 2026 increase based on this year's recommended update is 5.30 percent.

The 5.30 percent is used to estimate CY 2026 hospital spending per capita for Maryland in our savings evaluation. As explained above, the AHEAD Medicare FFS TCOC savings targets are based on USPCC trends, these trends are used in the following evaluation which illustrates two scenarios. The State is continuing to work through the details of the methodology with CMMI. A few areas of uncertainty remain. These include:

- Confirming actual claims experience under AHEAD calculation methodology, in comparison to TCOC actuals.
- Finalizing 2025 values, particularly for Non-claims based payments
- Confirming calculation of HCC scores (uses v28)
- Finalizing the appropriate USPCC values to be used

The first scenario, outlined in Table 6a below, is based on the 2026 USPCC data published by CMS in 2025.

**Table 6a: AHEAD Estimate (Scenario 1, 2025 Trended forward at USPC Year-1 Trend)**

Scenario 1 Guardrail Projections			
	Maryland	Target (includes savings)	Impact
YOY Growth 2026	5.2%	4.0%	
Cumulative Growth (2023 to 2026)	19.6%	18.7%	-0.9%
Estimated CY 2026 Savings Run Rate			-\$88.7 M dissavings

Under this scenario, national spending would grow at 4.0 percent in 2026, reflecting the Year -1 2026 USPC adjusted projected value. Meanwhile Maryland would grow at 5.2 percent in 2026, which reflects hospital spending driven by the CY2026 impact of the update factor of 5.30 percent and non-hospital spending which is assumed to grow at the rates set by USPC for Part A (1.6 percent) and Part B (6.0 percent). Under this scenario the State would miss the target by \$89M.

Medicare determined that it was making duplicative payments for MA-related IME and DGME costs (one payment directly to inpatient facilities, and one payment to MA plans through higher benchmarks), so in 2024, CMS began a three-year removal of MA-related IME and DGME spending from the non-ESRD FFS USPCs. This has resulted in lower USPC updates over 2024, 2025, and 2026 - Maryland AHEAD's two interim years and the first PY. The State has urged CMMI to remove this technical adjustment from the USPC for the savings test as it is not relevant for AHEAD and CMMI has conceptually agreed that an adjustment is appropriate but the nature and scope of any adjustments has not been finalized.<sup>8</sup>

The second scenario, outlined in Table 6b below, represents Staff's estimate of Maryland's results with the IME adjustment. While Staff believe the IME adjustment will result in a significantly improved position under the test, the State can not be sure of the impact until final notification is received from CMMI. Staff believe greater weight should be placed on Scenario 2 than Scenario 1 given the likely IME adjustment but Staff have not removed Scenario 1 as the impact of the

<sup>8</sup> A summary of the decision and actions taken can be found in the following MedPac document: [https://www.medpac.gov/wp-content/uploads/2025/02/02102025\\_MA\\_PD-AN-CY-2026\\_MedPAC\\_COMMENT\\_v2\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2025/02/02102025_MA_PD-AN-CY-2026_MedPAC_COMMENT_v2_SEC.pdf)

adjustment remains uncertain and Scenario 1 therefore provides a floor for possible savings projections.

Under Scenario 2, national spending would grow at 5.3 percent for CY2026, reflecting the Year -1 2026 USCPC adjusted projected value without the IME removal. Meanwhile, Maryland would grow at the same pace as described in Scenario 1. In addition, Maryland would enter 2026 in a stronger position due to the higher trends allowed for 2024 and 2025, thus Maryland would comfortably meet its target.

**Table 6b: AHEAD Estimate (Scenario 2, 2025 Trended forward at USPC Year-1 Trend with IME adjustment to 2024 to 2026 trends)**

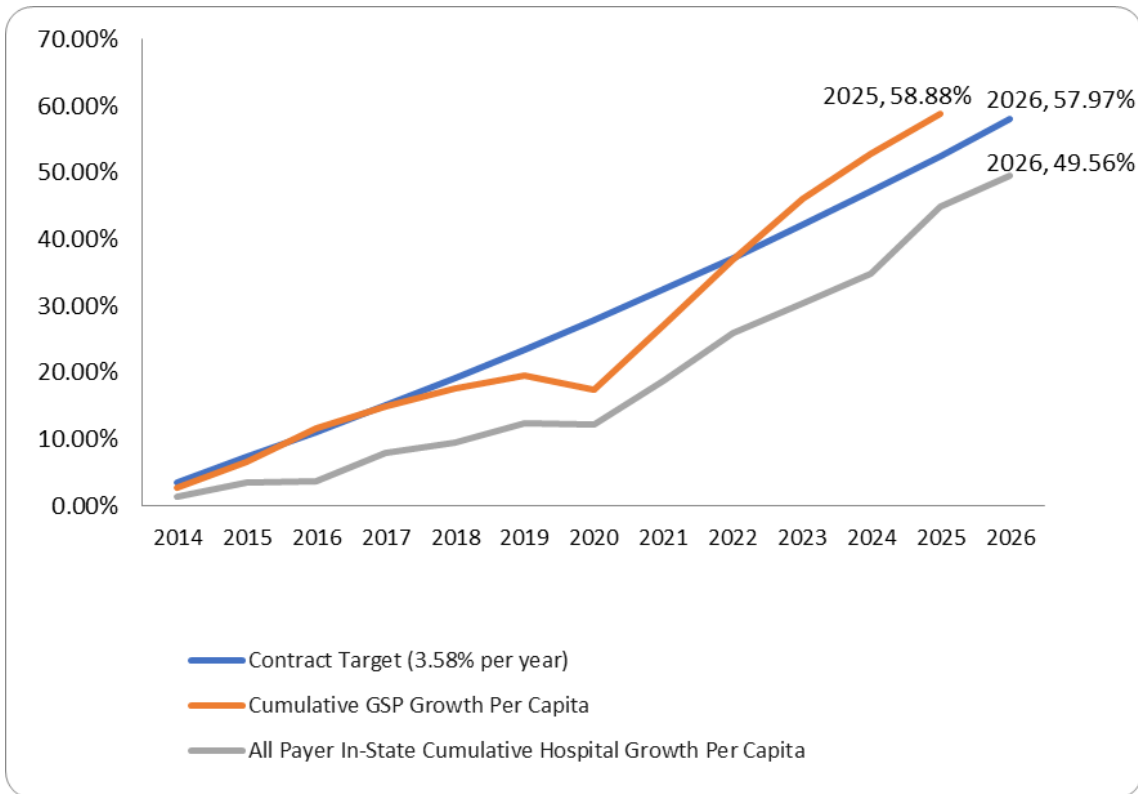
Scenario 2 Guardrail Projections			
	Maryland	Target (includes savings)	Impact
YOY Growth 2026	5.2%	5.3%	
Cumulative Growth (2023 to 2026)	19.6%	21.8%	+2.2%
Estimated CY 2026 Savings Run Rate			\$260.8 M savings

**All-Payer Affordability**

Under the AHEAD all-payer test, all-payer in-state hospital charge growth cannot grow at above 3.58 percent per annum over the life of the contract (3.58 percent was intended as an approximation of typical per annum Gross State Product (GSP) growth). Figure 2 represents the cumulative comparison since the beginning of global budgets in 2014. The blue line reflects the contract target, the orange line shows actual cumulative GSP growth through 2025, and the gray line reflects estimated cumulative in-state hospital charge growth per capita through 2026. Staff emphasize that this analysis includes hospital spending only and does not incorporate non-hospital components of total cost of care. The GSP line ends in 2025 due to the absence of official 2026 data, staff opted not to project GSP growth. However, even with no GSP growth in 2026, Maryland would remain under both the cumulative target and actual GSP growth. The cumulative value of this target through CY 2026 is 57.97 percent. Actual all-payer in-state hospital charge growth through CY 2025 is 44.85 percent, inflating this to 2026 using the recommended update factor on a per capita basis yields 49.56 percent. This means that Maryland is

approximately 8.8 percentage points below the contract target, which reflects system-wide savings achieved through Maryland’s total cost of care framework and carried forward under the AHEAD Model that accrue to all payers and consumers.

**Figure 2**  
**Affordability Scorecard – Cumulative GSP Test with CY 2026 Projection**

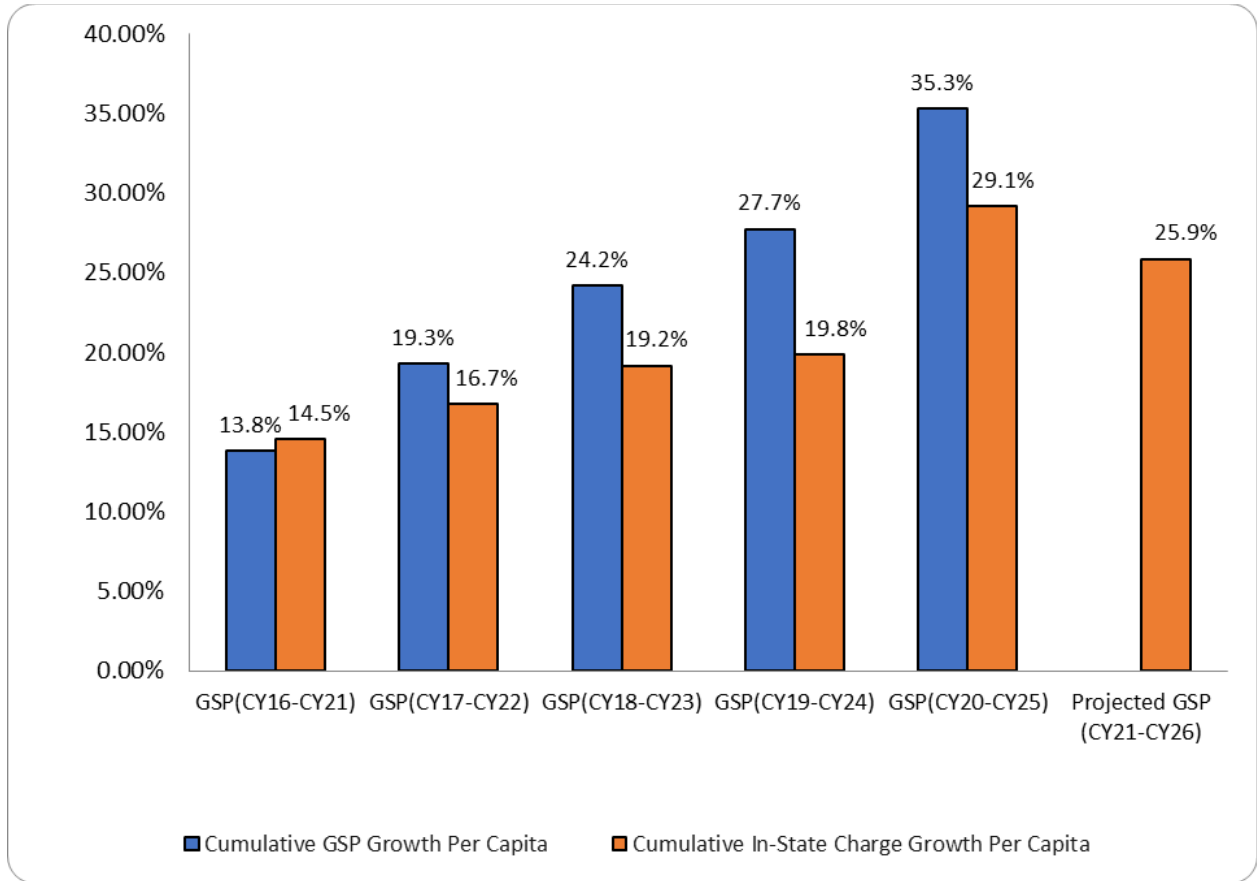


Staff also compared the all-payer in-state hospital charge growth to economic growth in Maryland, as measured by the GSP per capita, over a rolling 5-year window. The purpose of this modeling is to ensure that healthcare remains affordable in the State, for this purpose staff believe it is not sufficient to only look at the cumulative test embedded in the AHEAD Contract. Therefore, staff calculated the cumulative per capita growth for the five-year period using the most updated State GSP numbers available. As shown in Figure 3, the 5-year calculation shows a cumulative per capita growth of 37.6 percent. Staff then compared that number to the 5-year cumulative in-state acute hospital charge growth over the same five-year window, which equals 29.1 percent. Staff

also modeled estimated hospital charge growth through CY 2026 using the proposed RY 2027 update factor. This projection results in estimated hospital charge growth of 25.9 percent.

This rolling five-year test provides a complementary view to the cumulative analysis. While the margin between hospital charge growth and GSP is smaller under this test, the results still indicate that hospital spending growth remains below the State’s economic growth, reinforcing the affordability goals of the Model.

**Figure 3**  
**Affordability Scorecard – Rolling 5-Year GSP Test**



**Medicare’s Proposed National Rate Update for FFY 2027**

CMS released its proposed rule for the Inpatient Prospective Payment System’s (IPPS) payment rate on April 10, 2026. In the proposed rule, CMS would increase rates by approximately 2.40 percent, which includes a market basket increase of 3.20 percent and a productivity reduction of -0.80 percent. This proposed increase will not be finalized until August 2026 and will not go into effect until October 1, 2026. This also does not take into account volume changes, nor does it take into account projected reductions in Medicare disproportionate share hospital (DSH)

payments and Medicare uncompensated care payments, as well as potential reductions for additional payments for inpatient cases involving new medical technologies and Medicare Dependent Hospitals.

## Stakeholder Comments

Staff worked with the Payment Model Workgroup to review and provide input on the proposed RY 2027 update. Comments submitted by stakeholders primarily focused on the following areas: monitor inflation throughout the rate year, prospectively adjust the UCC provision in rates, provide additional funding to support hospital readiness for H.R. 1 an AHEAD, distribute the national demand modifier based on age-adjusted demographic growth, delay HOPE implementation pending access and latent demand concerns, limit hospital revenue growth and update factor increases, align HSCRC methodologies with AHEAD/CMMI, fund CTI rewards for RY 2025 performance, and discontinue the productivity adjustment for non-GBR hospitals.

Comment letters were received from the following entities: The Maryland Hospital Association (MHA), Adventist Healthcare, Frederick Health, Johns Hopkins Health System, MedStar Health University of Maryland Medical System, Luminis Health, Mount Washington Pediatric Hospital, J Kent McNew, Sheppard Pratt, Brook Lane Maryland Healthcare for All, Health Means Everything Alliance, and CareFirst. The comments are outlined below with staff's response in italics:

### 1. Monitor Inflation throughout the Rate Year

The Maryland Hospital Association (MHA) and its member hospitals expressed concern that economic volatility and current cost pressures, including rising energy and labor costs, may not be fully reflected in current forecasts. MHA requested that the Commission continue monitoring inflation throughout the rate year to ensure the inflation allowance remains adequate if actual inflation exceeds projections. Luminis Health noted that recent Producer Price Index trends for energy and supplies appear to exceed current S&P Global inflation projections. MedStar Health requested that the Commission consider suspending the inflation catch-up methodology for FY 2027 and provide the full underfunded inflation amount, which MedStar estimated would provide hospitals with an additional 0.25 percent. In contrast, CareFirst BlueCross BlueShield expressed concern regarding the calculation of the 0.20 percent inflation catch-up adjustment, stating that the most recent FY 2025 data was not incorporated into the corridor analysis. CareFirst recommended recalculating the inflation methodology using the most current available data and reiterated prior concerns regarding the selected base year for the policy.

*HSCRC Response: Staff review inflation with every quarter book that S&P publishes. The catch-up methodology was specifically designed to provide additional inflation beyond the risk tolerance guardrail of 0.25 percent. Should actual inflation come in higher than what*

*was funded and it trips the guardrail, Staff will provide additional inflation in line with the catch-up methodology. Staff also think it is important to note that the guardrail was lowered last year from 1 percent to 0.25 percent as part of the RY 2026 Update Factor Recommendation and there were years where hospitals were overfunded, prior to the catch-up methodology being put in place, that Staff did not remove inflation.*

*In response to CareFirst's concerns with not using the most current year available data. Staff do not consider inflation to be complete until 7 quarters of data have passed since the funded value was put into rates. Including a year that is incomplete adds an additional reconciliation to be completed as part of the process and would add unnecessary complexity. Staff do think it is important to note that while we don't include the most current year's actual inflation in the catch-up methodology, we do include any catch-up inflation that was included in that year's calculation.*

## **2. Prospectively Adjust the UCC Provision in Rates**

MHA, Adventist Health Care, John Hopkins Health System (JHHS), MedStar Health, Luminis Health and the University of Maryland Medical System (UMMS) requested that the Commission prospectively adjust the uncompensated care (UCC) provision in rates by 0.69% for RY 2027 to reflect projected Medicaid and marketplace coverage losses resulting from federal policy changes. Additionally, they noted that under current policy, increases in UCC would not be reflected in rates until RY 2029, creating what Adventist described as an “operationally untenable” two-year lag while hospitals are already experiencing increased bad debt and charity care pressures.

*HSCRC Response: Staff have proposed supporting the Maryland Health Benefit Exchange Fund and the HSCRC's Uncompensated Care Fund in order to help reduce the loss of coverage and the resulting increase in uncompensated care and provide reserves should additional uncompensated care emerge. This element of the proposal is considered draft and stakeholders have another opportunity to comment before a final recommendation is adopted.*

## **3. Provide Additional Funding to Support Hospital Readiness for H.R.1 and AHEAD**

MHA, Adventist HealthCare, JHHS, MedStar Health, Luminis Health and UMMS requested that the Commission allocate an additional 0.30% to support hospital readiness for H.R.1 and the transition to AHEAD. Commenters stated that hospitals will need to make significant investments in staffing, revenue cycle operations, Medicare cost reporting, MS-DRG implementation, clinical documentation improvement, quality reporting alignment, and technology system upgrades to operate under bifurcated payment and regulatory systems beginning in 2028. Commenters also cited the administrative burden associated with assisting patients with Medicaid eligibility, coverage retention, and

enrollment disruptions resulting from federal policy changes. MedStar Health noted that hospitals will be required to simultaneously manage differing payment, operational, and reporting requirements under both the Total Cost of Care and AHEAD frameworks, while UMMS expressed concern that monitoring, rather than proactively addressing, H.R.1-related impacts would leave hospitals responsible for bearing the financial risk associated with a broad range of potential outcomes.

*HSCRC Response: Hospitals received \$25 million in one-time funding in RY2025 and \$50 million in permanent funding in RY2026 for AHEAD preparation. Permanent funding will remain in rates in perpetuity and get inflated each year moving forward. Staff do not agree that additional funding related to AHEAD preparation is warranted at this time. In addition, should HOPE get approved by the Commission, Hospitals are keeping all revenue that was at risk of a clawback as part of the high value care plans and prior to that for PAU.*

#### **4. Delay HOPE Implementation Pending Access and Latent-Demand Concerns**

Adventist HealthCare requested that the Commission delay implementation of the Healthcare Outcome Payment Effort (HOPE) framework until latent-demand and access concerns are fully evaluated and coordination with CMS is established. Adventist expressed concern that the current improvement-only methodology could disadvantage already efficient, low total cost of care regions and stated that low utilization in some areas may reflect unmet need rather than efficiency. Adventist also recommended that the Commission establish a framework to assess care access before implementing policies tied to TCOC performance.

Luminis Health supports the intent of the HOPE program. However, before any funds are withheld from the update factor to support the program, additional detail is needed regarding how savings will be measured, how clinical interventions will be evaluated and approved, and what guardrails will be implemented to protect the integrity of the program.

*HSCRC Response: While implementation of HOPE is being delayed with applications during FY 27 and performance periods generally starting in FY 28, Staff do not view these concerns and continued care transformation efforts as mutually exclusive. Staff believe these issues can continue to be evaluated and coordinated with CMS concurrent with ongoing HOPE development and implementation activities. Concerns with HOPE will be evaluated as the Commission reviews the HOPE recommendation.*

#### **5. Distribute the National Demand Modifier Based on Age-Adjusted Demographic Growth**

Adventist HealthCare & Frederick requested that the national demand modifier be distributed proportionally based on age-adjusted demographic growth rather than evenly

across hospitals statewide. The Hospitals stated that the current methodology creates a disconnect between the purpose of the adjustment and its distribution because hospitals facing significantly different demographic pressures receive the same allocation. They emphasized that funding intended to address aging population impacts should be directed toward regions experiencing the greatest demographic growth. Luminis Health additionally expressed concern that insufficient recognition of age-adjusted population growth during the AHEAD base period could create long-term financial challenges for hospitals experiencing higher demographic growth.

*HSCRC Response: Staff believe there is conceptual validity to this request. There is added complexity with adding this change after results have already been shared with the industry. In addition, the impact is relatively small. Staff agree to consider this enhancement as part of the broader policy review during the transition to split global budgets under AHEAD.*

## **6. Limit Hospital Revenue Growth and Update Factor Increases**

The Maryland HealthCare for All (MHCA) and Health Means Everything Consumer Alliance (HME) organizations expressed concern about the cumulative impact of consecutive hospital revenue increases on Maryland consumers and urged the Commission to limit update factor increases while protecting access to affordable, high-quality care. Both organizations stated that hospital revenue growth should not outpace broader economic and wage growth and recommended treating the draft recommendation as a cap on potential increases given ongoing affordability pressures facing Marylanders. CareFirst also emphasized the importance of balancing hospital financial stability with affordability for Maryland consumers. CareFirst noted that Maryland Medicare hospital payments per capita grew faster than the national average in 2025 and encouraged the Commission to prioritize performance under the AHEAD Model savings tests when finalizing the update factor recommendation.

*HSCRC Response: Staff appreciate the comments provided by The Maryland HealthCare for All (MHCA) and Health Means Everything Consumer Alliance (HME) organizations. The Update Factor recommendation is a balance between fairness and equity for hospitals, payers, and consumers. One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the Medicare Agreement. Applied to all payers in the system, the update factor determination ensures that the increases to hospital rates borne by all purchasers of hospital services, including consumers, is reasonable and affordable. To ensure All-Payer affordability, Staff measures our projected update against the GSP target of 3.58% in our contract and the actual GSP since 2014. For all years measured, the All-Payer In State Hospital growth has been lower than the contract target and actual GSP.*

*Should the projected Hospital growth ever be expected to grow beyond the contract target or actual GSP, staff would evaluate factors within the update to ensure continued affordability.*

## **7. Align HSCRC methodologies with AHEAD/CMMI**

UMMS encouraged the Commission to focus Staff efforts on aligning core methodologies with CMMI and transitioning to AHEAD. Specifically, they recommended prioritizing alignment, rather than divergence, on core issues such as carve outs, volume, and quality, while focusing on methodologies that represent the “core building blocks” for Commercial and Medicaid rate setting.

*HSCRC Response: Staff agree with these comments. Over the next six months of the calendar year, Staff will be working with stakeholders to align our current policies under AHEAD. There is a significant amount of consideration that will be going into this development. We appreciate the early feedback and ongoing support of stakeholders as we work to achieve alignment over the next several months.*

## **8. Fund CTI Rewards for RY 2025 performance**

MedStar Health expressed concern regarding the retrospective elimination of Care Transformation Initiative (CTI) rewards and penalties for FY 2025 performance, stating that hospitals made substantial investments in care coordination, population health, and clinical integration infrastructure based on anticipated CTI incentives. MedStar requested that the Commission consider using a portion of the CTI set-aside funds to provide bridge funding through at least FY 2028 for hospitals with established, high-performing CTI programs.

UMMS does not support ending the CTI policy without paying hospitals for their FY 2025 performance. UMMS and other commenters fully support a set aside in the update factor to fund hospitals and/or systems who have earned rewards within the CTI program.

*HSCRC Response: Staff have earmarked funding to provide to hospitals based on system level earnings that would have been paid out as part of the CTI rewards in RY2027 for the RY2025 performance year.*

## **9. Discontinue Productivity Adjustment for Non-GBR Hospitals**

MHA, UMMS, JHHS, Luminis Health, Brook Lane, Mt. Washington Pediatric Hospital, Sheppard Pratt, and J. Kent McNew Family Medical Center requested that the Commission discontinue the proposed 0.80 percent productivity adjustment for non-GBR hospitals and provide specialty hospitals with the full 3.37 percent inflation allowance

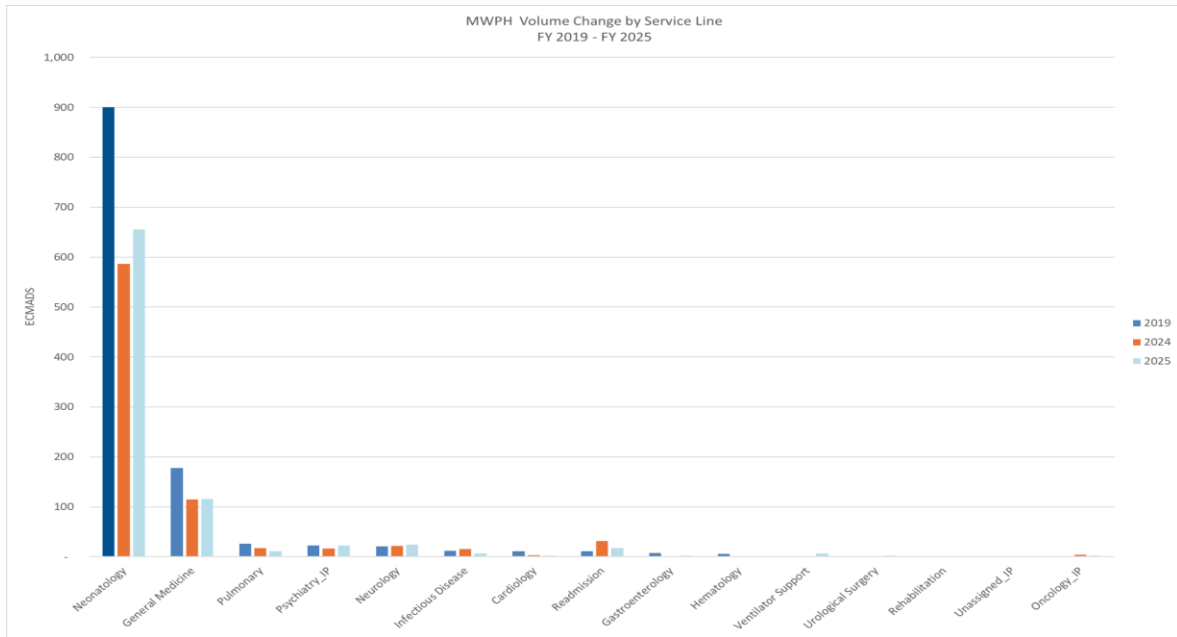
included in the draft recommendation. They stated that specialty behavioral health and pediatric providers face significant labor shortages, rising operating costs, limited capacity, and low reimbursement rates while caring for clinically complex and vulnerable patient populations. The letters expressed concern that reinstating the productivity adjustment could further strain access to care, staffing, and financial stability for providers that play a critical role in Maryland's healthcare system.

*HSCRC Response: Staff followed the formulaic approach in the development of the draft recommendation by applying the productivity adjustment of -0.80 percent, in line with the proposed IPPS rule for FFY 27. The productivity adjustment is a tool that aligns Medicare payment updates with broader economic productivity trends, promoting cost control and efficiency in hospital operations. A productivity adjustment is applied to hospitals under both IPPS and IPF PPS. HSCRC staff do not set Medicare rates for non-GBR hospitals. The proposed update is included for non-governmental payers. HSCRC staff understand that non-GBR hospitals are facing similar cost pressures to GBR hospitals. Volumes at these hospitals are still down relative to a 2019 base and as these volumes declined, they were removed based on a 100 percent variable cost factor. These hospitals are a valuable resource in the Maryland healthcare ecosystem. It is important that they have the ability to respond to the needs of the community and be available as a statewide resource in specialty hospital care for pediatrics and psychiatric services.*

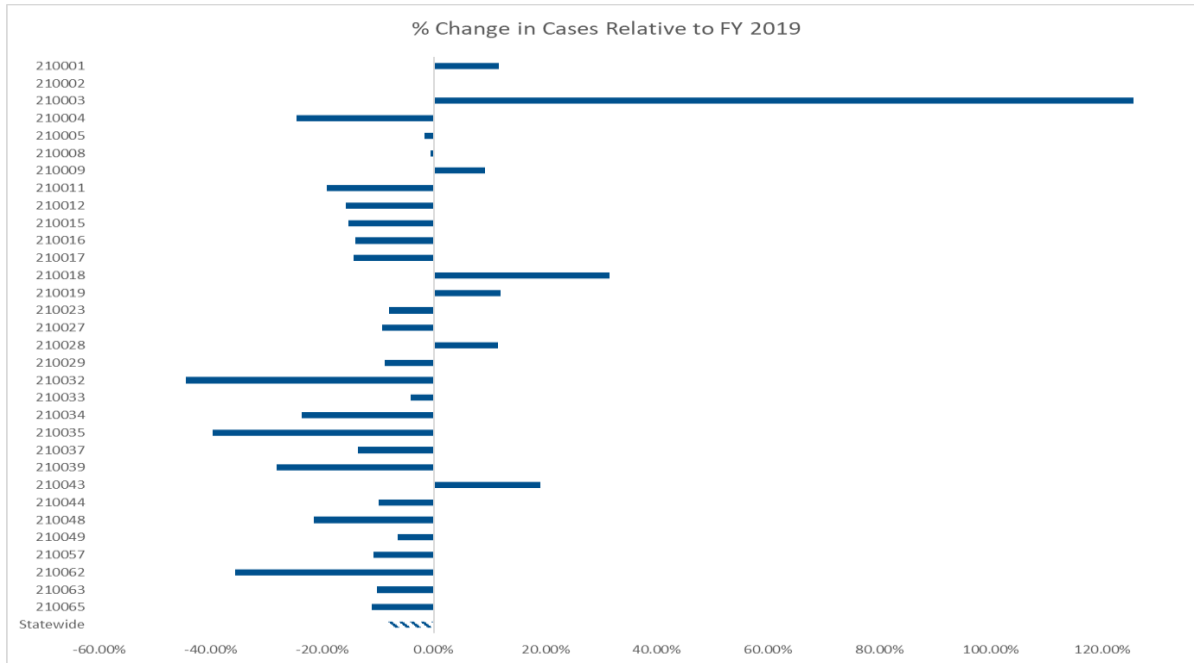
*Staff reviewed additional analyses described below, to better understand the volume declines at these hospitals. For purposes of our analytics, we focused on the two specialty hospitals with the largest revenue bases - Sheppard Pratt & Mount Washington Pediatric Hospital.*

- a. Staff reviewed trends in hospital abstract volume at Mount Washington Pediatric Hospital and Sheppard Pratt from Fiscal Year 2019 (pre-pandemic) to Fiscal Year 2025 (most recently completed fiscal year). For Mount Washington, inpatient volumes decreased by 327 cases, as measured by the Commission's casemix adjusted methodology (ECMADS). Approximately 75 percent of this reduction was due to neonatology (see Figure 4a below) and this largely aligned with statewide experience amongst general acute care facilities, with few exceptions, (see Figure 4b below), suggesting a secular decline in demand of neonatology, e.g., fewer premature births.*

**Figure 4a**  
**Mount Washington Pediatric Hospital Volume Change by Service Line**

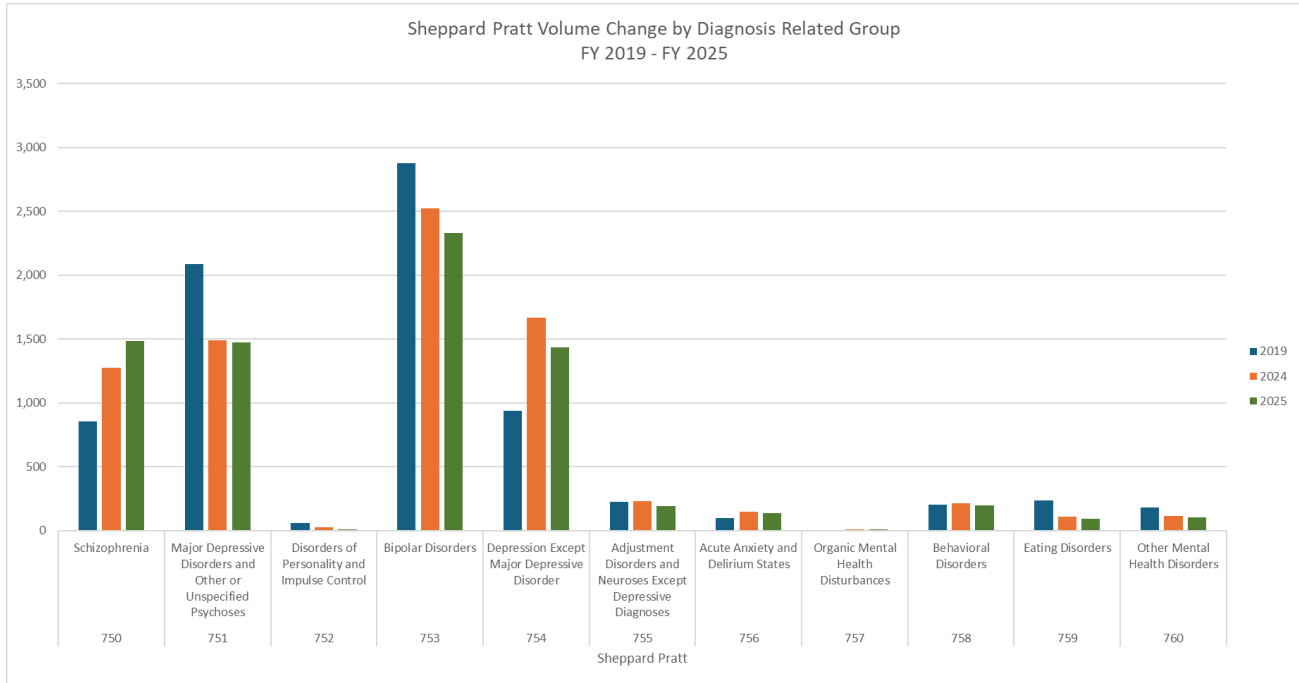


**Figure 4b**  
**Fiscal Year 2025 Percentage Change in Neonatology Cases Amongst General Acute Care Facilities**



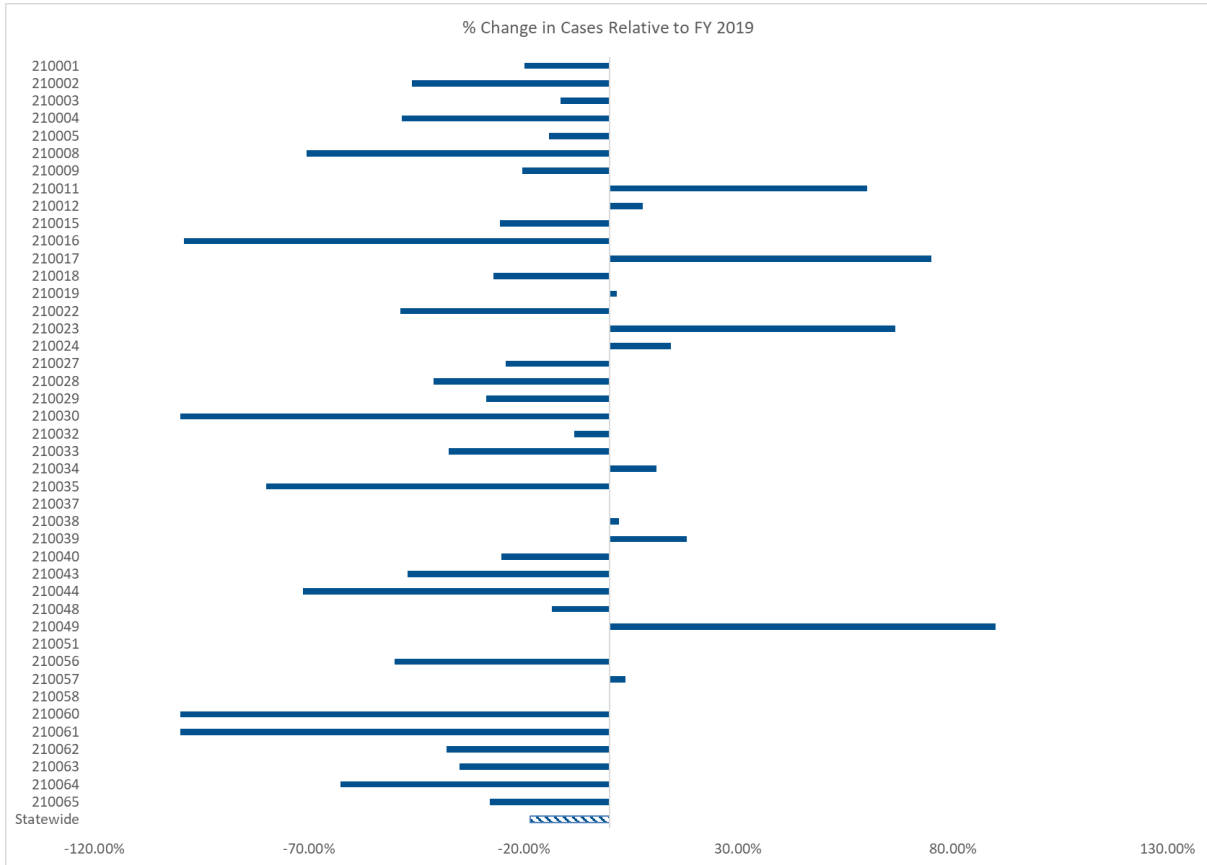
*At Sheppard Pratt, inpatient volumes declined by 298 cases; however, the reduction was not localized to one service line or diagnosis related group, as various cases, e.g., schizophrenia, trended upwards, but other cases, e.g., bipolar disorders and eating disorders, saw significant reductions that entirely offset other emerging behavioral health services (see Figure 5a below).*

**Figure 5a**  
**Sheppard Pratt Volume Change by Service Line**



*Staff noted a similar decline in behavioral health admissions among general acute care facilities (18 percent statewide), with a few notable exceptions, suggesting another potential secular decline in demand.*

**Figure 5b**  
**Fiscal Year 2025 Percentage Change in Behavioral Health DRG's Amongst General Acute Care Facilities\***



\*Removed outliers: University of Maryland Shore Health at Easton and Doctors Community Health, who recently ramped up their Behavioral Health programs.

*In light of the analyses described above, staff agree to waive the productivity adjustment for RY 2027. Staff also believe that moving forward exploration of productivity adjustment alternatives should be considered.*

## Recommendations

Based on the currently available data and the staff's analyses to date, HSCRC staff provides the following final recommendations for the RY 2027 update factors.

For Global Revenues:

- (a) Provide all hospitals with a gross inflationary increase of 3.37 percent, including an additional 0.20 percent to support revenue needs based on historical underfunding of inflation, and 0.06 percent allocated based on each hospital's proportion of drug costs.
- (b) Provide an overall increase of 4.07 percent for revenue (including a net increase to uncompensated care) and 3.95 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets: a mid-year target and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target, and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.
- (c) Provide additional funding related to uncompensated care to the Maryland Health Benefit Exchange Fund of 0.40 percent to support reinsurance and subsidies for marketplace enrollees and 0.10 percent to increase the reserve held in the HSCRC's Uncompensated Care Fund to be released as additional uncompensated care emerges. This element is a draft recommendation and will be removed from the update factor if the final recommendation is not approved subsequently.

For Non-Global Revenues, including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- (a) Provide an overall update of 3.17 percent for inflation and additional inflation of 0.20, for a total update of 3.37 percent. Suspend the productivity adjustment for RY 2027.

## Appendix I: Set Aside Reconciliation

Distribution of Set Aside for RY 2026			
RY 2026 GBR Revenue		\$24,029,464,776	
Set Aside %		0.20%	
Set Aside \$		\$48,058,930	
Hospital	Set Aside \$ Value	Set Aside %	Reason
Tidal Health - PRMC	\$11,551,709	0.05%	IE - GME Residents
Garrett	\$2,766,682	0.01%	Change in 340B eligibility to sole community provider
UCHS/Aberdeen	\$2,900,000	0.01%	Combined Surge Funding
MedStar	\$22,359,625	0.09%	IE (FS, Harbor, St. Mary's)
Frederick	\$2,000,000	0.01%	Cyberattack
PAU Redistribution for FMF Conversion	\$6,161,114	0.03%	-
Total	\$47,739,130	0.20%	
Set Aside Remaining	\$339,799	0.00%	

In RY 2026, the Commission recommended distributing approximately \$48 million in Set Aside funding. This funding allocation represents 0.20 percent of total approved GBR revenue for the

year and is targeted toward hospitals with demonstrated unforeseen circumstances that may cause financial hardship or existing commitments to Integrated Efficiency initiatives.

## Appendix II: Revenue for Reform

Revenue for Reform is intended to safe harbor population health investments from the HSCRC Integrated Efficiency Policy, which would otherwise withhold dollars from hospitals with excess retained revenue relative to their peers. This policy ensures that hospital-retained revenue which is directed toward meaningful community-based population health initiatives is not reclaimed as "inefficient".

The primary objectives of the Revenue for Reform policy are to:

- Direct hospital-retained revenue into community-based population health investments, fostering overall health improvement.
- Support projects aligned with the TCOC Model's goals to improve population health and reduce total cost of care.
- Establish a self-sustaining cycle in which reduced hospital service demand leads to increased hospital investment in community health.

Under this policy, hospitals are required to invest in approved community health activities or return funds to payers. Hospitals authorized to make population health investments are required to maintain annual spending on population health initiatives, ensuring that the funding is utilized for sustainable health investments.

In FY 2026, approximately \$60 million was directed to community health and expanding/maintaining access to primary care and behavioral health providers in Baltimore City, Carroll County, the Eastern Shore, and the DC Metro region. Most investments approved in FY 2026 were continuations of approved FYs 2024 and 2025 investments. Staff waived penalties and safe harbor requirements associated with new FY 2026 IE results due data delays that impacted their release. Only two hospitals, Sinai Hospital and University of Maryland Shore Medical Center at Chestertown, were impacted by the FY 2026 IE results and will incorporate those results into their FY 2027 R4R applications.

Total Eligible for Safe Harbor	
<ul style="list-style-type: none"> <li>• FY 2024 Permanent Revenue: \$23,840,552</li> <li>• FY 2025 Permanent Revenue: \$39,771,749</li> <li>• FY 2026 Permanent Revenue: Waived until FY27</li> </ul>	\$63,612,301
Approved for Safe Harbor	\$60,070,024
Permanent Savings to Payers	\$3,542,277

<b>Hospital</b>	<b>Investments in Pop Health &amp; Provider Access</b>	<b>Approved Program/Interventions</b>
Johns Hopkins Bayview Medical Center	\$14,021,944	<ul style="list-style-type: none"> <li>● Care management/transitions for high-risk and rising risk patients</li> <li>● Primary, specialty, and post-acute care for uninsured and undocumented populations</li> <li>● Pediatric and OBGYN – FQHC support</li> <li>● HRSN screening and referrals</li> <li>● Behavioral healthcare expansion</li> </ul>
Lifebridge Carroll Hospital Center	\$2,484,359	<ul style="list-style-type: none"> <li>● Care management/transitions for high-risk and rising risk patients</li> <li>● Primary care for uninsured and underinsured patients</li> </ul>
Lifebridge Sinai Hospital	\$21,791,363	<ul style="list-style-type: none"> <li>● Care management/transitions for high-risk and rising risk patients</li> <li>● Wraparound services/HRSN supports for patients with advanced chronic conditions and SUD</li> <li>● Diabetes prevention &amp; management and wraparound services</li> <li>● Community violence intervention</li> <li>● Physician Practices in HPSA/MUAs</li> </ul>
St. Agnes Hospital	\$1,050,599	<ul style="list-style-type: none"> <li>● Care management/transitions for high-risk and rising risk patients</li> </ul>
Union Hospital of Cecil County	\$1,651,197	<ul style="list-style-type: none"> <li>● Care management/transitions for high-risk and rising risk patients</li> <li>● HRSN screening and referrals</li> <li>● Physician Practices in HPSA/MUAs</li> </ul>
University of Maryland Capital Region Medical Center	\$3,207,995	<ul style="list-style-type: none"> <li>● Physician Practices in HPSA/MUAs</li> </ul>
University of Maryland Medical Center Midtown Campus	\$4,688,845	<ul style="list-style-type: none"> <li>● Care management/transitions for high-risk and rising risk patients</li> <li>● Care management/transitions for patients with SUD</li> <li>● Physician Practices in HPSA/MUAs</li> </ul>
University of Maryland Shore Medical Center at Chestertown	\$1,776,248	<ul style="list-style-type: none"> <li>● Care management/transitions for high-risk and rising risk patients</li> </ul>
University of Maryland Shore Medical Center at Easton	\$5,779,980	<ul style="list-style-type: none"> <li>● Care management/transitions for high-risk and rising risk patients</li> </ul>

University of Maryland St. Joseph Medical Center	\$2,561,803	<ul style="list-style-type: none"> <li>● Care management/transitions for high-risk and rising risk patients</li> <li>● Primary care and behavioral health services for uninsured and undocumented populations</li> </ul>
Washington Adventist Hospital	\$1,055,691	<ul style="list-style-type: none"> <li>● Physician Practices in HPSA/MUAs</li> </ul>

Hospitals submit applications to secure safe harbor status for investments through two tracks.

1. Track 1: Community Health Investments
  - Track 1A: Multidisciplinary Care Transitions and Care Management Programs
    - Directs spending to address leading conditions driving avoidable hospital utilization, readmissions, and healthcare costs.
    - Implements tailored, multidisciplinary care transitions and care management programs.
  - Track 1B: Evidence-Based Community Health Improvement Programs
    - Supports the implementation of new or existing evidence-based community health improvement programs within a hospital's primary service area.
2. Track 2: Physician Spending
  - Facilitates investment in primary care, mental health providers, and dental providers in designated Health Professional Shortage Areas (HPSA) or Medically Underserved Areas (MUA).

Applications are reviewed by a cross-functional team from the HSCRC and Maryland Department of Health against track-specific evaluation criteria. Staff approve, deny, or request revisions to submitted applications.

## Appendix III: Comment Letters

- Mount Washington Pediatric Hospital
- Brook Lane
- J. Kent McNew Family Medical Center
- Sheppard Pratt
- Maryland Healthcare for All (MHCA)
- Maryland Hospital Association (MHA)
- Adventist HealthCare
- Health Means Everything Consumer Alliance (HME)
- Frederick Health
- John Hopkins Health System (JHE)
- MedStar Health
- Luminis Health
- CareFirst
- University of Maryland Medical System (UMMS)



**Mt. Washington  
Pediatric Hospital**

*Where Children Go to Heal and Grow*

*Est. 1922*

An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

April 28, 2026  
Jon Kromm  
Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

**RE: MWPB Comment Letter on Draft Staff Recommendation for the FY 2027  
Update Factor**

Dear Mr. Kromm,

On behalf of Mt. Washington Pediatric Hospital, I am submitting comments in advance of the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Update Factor for Rate Year 2027.

The HSCRC is considering a productivity adjustment of -0.80% for Mt. Washington Pediatric and the other non-global budget hospitals.

I am writing to ask that Mt. Washington be provided the full update factor provided to the global budget hospitals, and that the productivity adjustment be discontinued.

As you know, MWPB admits medically fragile children who no longer need acute care services, but cannot yet go home. Referring hospitals look to Mt. Washington as a crucial partner in their efforts to reduce unnecessary volume and cost, by assuring that services are provided in the appropriate, lowest-cost setting. Transfers to MWPB also serve to keep higher-acuity NICU and PICU beds available for children who need them.

In addition to providing specialty medical care, Mt. Washington specializes in the family training and discharge planning that is so crucial to a safe transition for these hospitalized children, 75% of whom are covered by Medicaid.

Mt. Washington also provides outpatient rehabilitation, behavioral health and medical services to children with chronic and/or complex medical conditions. These services can be difficult to access in the community, particularly for the 50% of our outpatients covered by Medicaid, and particularly for children with complicated, time-consuming medical challenges.

Accredited by The Joint Commission  
and by Commission on Accreditation  
of Rehabilitation Facilities

[mwph.org](http://mwph.org)

**Mt. Washington Pediatric Hospital**  
1708 West Rogers Avenue  
Baltimore, Maryland 21209  
410-578-8600

**Mt. Washington Pediatric Hospital  
at UM Capital Region Medical Center**  
901 North Harry S. Truman Drive,  
8th Floor, Largo, Maryland 20774  
240-677-1800 (inpatient)  
240-677-1850 (outpatient)



# Mt. Washington Pediatric Hospital

*Where Children Go to Heal and Grow*

*Est. 1922*

An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

Although it provides specialty, post-acute care, MWPH is subject to the same inflationary pressures as acute care hospitals, particularly for salaries. Clinicians with the specific expertise needed to treat our medically fragile children are in short supply. Salaries for pediatric nurses, psychologists and rehabilitation therapists have increased faster than inflation: the average rate MWPH has paid for these specialties have increased by 9% in the past year; by 27% over the past three years; and by 28% over the past five years. The productivity adjustment would further hinder our efforts to match market salaries, and therefore limit admissions, lengthen stays in acute care, and reduce access to care for outpatient services.

Volume growth at MWPH is already limited by payers. Insurers frequently review inpatient cases to assure that admissions are clinically appropriate and inpatient stays do not last longer than is medically necessary.

At the same time, the care of neonates has evolved over the past few years and MWPH is seeing a reduction in inpatient admissions. During this same period, outpatient demand has increased. This has exacerbated financial challenges for MWPH, as it sees reductions in its higher-margin inpatient work, and expands lower-margin but critically needed outpatient psychology, rehabilitation, primary care for medically fragile children, and other services.

The hospital is on track to lose \$10 million on operations in FY 2026. A rate increase at less than the inflation factor would further threaten the hospital's ability to provide access to specialty care for Maryland's children.

For these reasons, we request that Mt. Washington Pediatric Hospital receive the same inflation support as the global revenue hospitals, and that the HSCRC eliminate a productivity adjustment that is both unnecessary and counterproductive

I appreciate your consideration of this proposal. Please contact me if you have any questions.

Sincerely,

Scott Klein, MD, President and CEO  
Mt. Washington Pediatric Hospital

Accredited by The Joint Commission  
and by Commission on Accreditation  
of Rehabilitation Facilities

[mwph.org](http://mwph.org)

**Mt. Washington Pediatric Hospital**  
1708 West Rogers Avenue  
Baltimore, Maryland 21209  
410-578-8600

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240-677-1850 (outpatient)



# Mt. Washington Pediatric Hospital

*Where Children Go to Heal and Grow*

*Est. 1922*

An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

Cc: Joshua Sharfstein, MD, Chairman

James Elliott, MD, Vice Chairman

Nicki McCann, JD

Jonathan Blum, MPP

David N. Maine, MD

Farzaneh Sabi, MD

Ricardo R. Johnson

Allan Pack, Principal Deputy Director

Jerry Schmith, Principal Deputy Director

Noel Sousa, UMMS, CFO

Alicia Cunningham, UMMS, SVP

Accredited by The Joint Commission  
and by Commission on Accreditation  
of Rehabilitation Facilities

[mwph.org](http://mwph.org)

**Mt. Washington Pediatric Hospital**

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240-677-1850 (outpatient)



# BROOK LANE

*Hope • Healing • Recovery*

an affiliate



April 28, 2026

Maryland Health Services Cost Review Commission (HSCRC)

Re: **Productivity Adjustment – Recommendation for Continued Suspension**

Dear Commissioners:

On behalf of Brook Lane Health Services, I am writing to express concern regarding the potential reinstatement of the productivity adjustment and to respectfully request its indefinite suspension, or at a minimum, continued suspension for Rate Year (RY) 2027.

As a specialty behavioral health system, Brook Lane provides a full continuum of psychiatric care—including inpatient, partial hospitalization, residential treatment, and outpatient services—for children, adolescents, and adults with complex needs. These are individuals who cannot be safely or effectively treated in general acute care hospitals. Our services play a critical role in reducing emergency department boarding, supporting hospital throughput, and ensuring access to care for some of Maryland's most vulnerable populations.

The proposed productivity adjustment is fundamentally misaligned with the realities of behavioral healthcare delivery. Length of stay and throughput in psychiatric settings are often driven by external system constraints, including limited step-down capacity, placement challenges, and social determinants of health. These are not inefficiencies that can be resolved through internal operational changes. Applying a productivity expectation in this context risks incentivizing care decisions that could compromise patient safety and quality.

Behavioral health care is also highly labor intensive and dependent on a specialized workforce that remains in short supply. Maintaining safe staffing ratios requires licensed clinicians with specific expertise, and these roles are not easily substituted or scaled. As the workforce has not rebounded to pre-pandemic levels, Brook Lane—like many providers—has increasingly relied on contract and locum tenens professionals to meet patient demand, significantly increasing labor costs. The productivity adjustment further constrains our ability to offer competitive compensation and recruit and retain the staff necessary to sustain access to care.

Additionally, specialty hospitals operate at a structural disadvantage within Maryland's payment system. Unlike hospitals under the Global Budget Revenue (GBR) model, Brook Lane does not benefit from a fixed revenue base and remains vulnerable to fluctuations in utilization and rising costs. Years of productivity adjustments, combined with already constrained reimbursement from Medicare and Medicaid, have created a growing gap between the cost of care and reimbursement. Reinstating the adjustment in RY 2027 would exacerbate this inequity and further destabilize providers that are essential to the state's behavioral health infrastructure.



# BROOK LANE

*Hope • Healing • Recovery*

an affiliate



Demand for behavioral health services—particularly for children and adolescents—continues to exceed available capacity. At Brook Lane, staffing and physical capacity already limit our ability to expand services despite clear and growing need. Policies that erode financial stability will have the unintended consequence of reducing access, increasing wait times, and placing additional strain on emergency departments and community providers.

For these reasons, we respectfully urge HSCRC to indefinitely suspend the productivity adjustment, or at a minimum, extend its suspension through RY 2027 to allow for further evaluation of its appropriateness for specialty behavioral health providers.

Thank you for your consideration and for your continued commitment to ensuring access to high-quality behavioral healthcare across Maryland.

Sincerely,

Allen L. Twigg, LCPC, FACHE  
Chief Operating Officer  
Brook Lane Health Services, Inc.

April 29, 2026

Dr. Jon Kromm  
Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Dr. Kromm,

I am writing on behalf of Luminis Health J. Kent McNew Family Medical Center to respectfully urge the Health Service Cost Review Commission to indefinitely suspend the productivity adjustment for specialty hospitals.

J. Kent McNew Family Medical Center is a standalone mental health facility providing both inpatient and outpatient services. With sixteen inpatient beds, a psychiatric hospital, and an intensive outpatient treatment program, the facility plays a vital role in caring for some of our community's most vulnerable individuals who cannot be safely or effectively treated in other settings. Facilities like McNew are essential to alleviating pressure on emergency departments, reducing avoidable hospitalizations, and supporting better long-term outcomes for patients and their families.

J. Kent McNew continues to face significant financial pressures. The need for highly specialized staff, fluctuations in patient volume, acuity of the patients, and the low reimbursement rates relative to the cost of care provided are contributing factors. Applying the productivity adjustment, substantially reduces the inflation update and further exacerbates these pressures which already threaten access to care.

In summary, the application of the productivity adjustment to specialty hospitals fails to recognize the indispensable role these facilities play in Maryland's healthcare system and support these providers play in meeting the State's priorities. Suspending the productivity adjustment for specialty hospitals is one of necessary steps needed to assist in preserving critical access to care and long-term financial stability.

Thank you for your thoughtful consideration of this matter.

Sincerely,



Kathy Talbot

VP of Revenue Strategy & Optimization

CC: Dr. Joshua Sharfstein, Chairman



2001 Medical Parkway  
Annapolis, Md. 21401  
[LuminisHealth.org](http://LuminisHealth.org)

Dr. James Elliott, Vice Chair  
Jon Blum, Commissioner  
Ricardo Johnson, Commissioner  
Dr. David Maine, Commissioner  
Nicki McCann, Commissioner  
Dr. Farzineh Sabi, Commissioner  
William Henderson, Principal Deputy Director  
Jerry Schmith, Principal Deputy Director  
Cait Cooksey, Deputy Director



# Sheppard Pratt

April 30, 2026

Jon Kromm, Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Mr. Kromm:

Although the HSCRC has not yet proposed a RY2027 update factor for non-GBR hospitals, in prior years staff have recommended reducing the inflationary update through a productivity adjustment. From RY2021 through RY2026, the productivity adjustment was included in draft recommendations but ultimately suspended in recognition of lower volumes and the inability to generate efficiencies or margin amid significant cost pressures. Sheppard Pratt requests that the productivity adjustment be permanently eliminated, or at a minimum suspended again for RY2027, with a commitment to discuss permanent elimination before RY2028.

The productivity adjustment assumes that variable hospitals can grow volume to improve margins. In RY2026, the rationale for suspending the productivity adjustment was tied to regulated volumes remaining below pre-pandemic levels. While we appreciate the suspension, that rationale does not translate well to psychiatric services. Demand for behavioral health care remains high, and Maryland continues to face shortages in providers and capacity. Although Sheppard Pratt's regulated volumes remain below pre-pandemic levels, the decline is driven exclusively by outpatient volume that has shifted to community-based settings—where care is often more appropriate and lower cost for consumers, but reimbursement is also lower, resulting in greater provider losses. Meanwhile, inpatient demand remains stable, and Sheppard Pratt typically operates at approximately 90% capacity, leaving little opportunity to increase volume to drive margin. In RY2025, inpatient volume declined due to rising acuity and resulting staffing shortages among nurses and direct-care staff, which required us to take beds offline for one quarter to maintain safe care. Even though the beds returned to service after one quarter, that temporary reduction in capacity affected other hospitals that rely on Sheppard Pratt for inpatient psychiatric transfers.

Sheppard Pratt plays a critical role in Maryland's health care continuum, serving a complex, acute, and underserved population while supporting acute care hospitals statewide through specialized inpatient capacity. We care for some of the State's most vulnerable patients who cannot be safely or effectively treated in other settings, which requires highly specialized, labor-intensive staffing. Maryland already faces a critical behavioral health workforce shortage, and any productivity adjustment further undermines our ability to recruit and retain nurses and direct-care staff. Rising inpatient acuity has increased the need for one-to-one—and at times two-to-one—staffing to ensure the safety of patients and staff. In addition, salary and benefit costs have risen sharply since the pandemic; maintaining safe staffing levels therefore requires higher overall staffing complements on our inpatient units. One example is our adult and adolescent



# Sheppard Pratt

neuropsych inpatient units, which serve patients with co-occurring neurological and psychiatric conditions resulting from brain injury or dysfunction. Patients may present with psychosis, aggression, self-injurious behavior, and/or elopement risk. Treating this population requires a comprehensive, multidisciplinary care team that understands the underlying clinical needs and can provide more specialized care than a conventional psychiatric unit.

As described in Sheppard Pratt's prior-year comment letters, the productivity adjustment applied between RY2013 and RY2020 has produced a cumulative reduction of more than 6% to base rates. This has contributed to a structural deficit driven by base rates that remain lower than reimbursement for comparable services provided in acute care settings. As a specialty psychiatric hospital, Sheppard Pratt receives Medicare and Medicaid reimbursement that is low relative to cost. In addition, because specialty hospitals are not part of the global budget model, we have less protection from utilization shifts and less ability to offset rising cost pressures—pressures that are amplified by the complexity of the population we serve.

Demand for psychiatric services has never been higher and Sheppard Pratt provides services that are unique in the market. Sheppard Pratt has experienced rising cost pressures over the past several years like the other Maryland hospitals and health systems. In many ways, Sheppard Pratt is less equipped than other health systems to manage the same cost pressures due to lower reimbursement for behavioral health services and receiving reduced reimbursement from our largest payers, Medicaid and Medicare. Labor and benefit costs drive the greatest expense increases, and the broader workforce environment leaves Sheppard Pratt with higher position vacancies and dependent on higher levels of agency staffing. Sheppard Pratt remains focused on maintaining services and staffing levels that support the broader community, including the acute care hospital systems in Maryland. Providing rate updates to Sheppard Pratt that are below the GBR hospitals creates a reimbursement parity issue that will be compounded over time, and which is not in alignment with the state's focus on creating access to behavioral health services.

We respectfully request that the Commission permanently eliminate the productivity adjustment, or at a minimum suspend it again for RY2027, and provide non-GBR hospitals an update factor equivalent to that provided to GBR hospitals. Thank you for your consideration. Please contact me if you have any questions.

Sincerely,

Kelly Savoca  
Senior Vice President and Chief Financial Officer



May 15, 2026

Maryland Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Members of the Health Services Cost Review Commission (HSCRC) Payment Model Workgroup,

Thank you for the opportunity to comment on the proposed update factor. [Maryland Citizens' Health Initiative](#) (MCHI) is a consumer health advocacy nonprofit whose mission is achieving quality, affordable health care for all Marylanders. As you consider the update factor, we urge you to consider how to protect consumers from skyrocketing health care costs and limit increases while protecting quality. A recent poll by Kaiser Family Foundation found that 1 in 3 adults have skipped or postponed getting needed health care because of cost in the last twelve months.<sup>1</sup> We appreciate all you do to expand and protect access to quality, affordable health care for all Marylanders.

Best regards,

Stephanie Klapper, MSW  
Deputy Director, Maryland Citizens' Health Initiative Education Fund Inc.  
[stephanie@healthcareforall.com](mailto:stephanie@healthcareforall.com)

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<sup>11</sup> <https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/>



Maryland  
Hospital Association

May 20, 2026

Dr. Jon Kromm  
Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, thank you for the opportunity to comment on the Health Services Cost Review Commission (HSCRC) Draft Recommendation for the Update Factors for Rate Year 2027. MHA appreciates the time staff have dedicated to ensuring a fair and reasonable update as well as their collaboration with stakeholders over the past several months on this important issue.

Maryland hospitals will be operating in a rapidly changing and challenging health care landscape in rate year 2027. The current economic environment, transition to bifurcated AHEAD Model policies, and federal policy changes impacting health coverage have added complexity and uncertainty at a time when many hospitals continue to confront financial challenges. MHA identified four ways HSCRC can strengthen its update factor recommendation to preserve access to care, ensure hospitals have sufficient resources for operational readiness and necessary investment, and help facilitate a successful transition to AHEAD, described below.

- **Monitor inflation throughout the rate year.** MHA supports the staff recommendation to fully fund inflation. Additionally, as economic volatility and contemporary cost pressures, including high and rising energy prices, introduce uncertainty and potential inflationary impacts that may not be captured in current forecasts, MHA recommends staff monitor inflation throughout the year to ensure the inflation allowance is adequate.
- **Prospectively adjust the uncompensated care (UCC) provision in rates by 0.69%.** H.R.1 and other federal policy changes are expected to result in significant Medicaid and Marketplace coverage losses. However, under HSCRC's current policy, increases in UCC in RY 2027 will not be reflected in rates until RY 2029. MHA estimates UCC levels could increase to 4.73% in FY 2027 (a 0.69% increase over FY 2025), based on state-estimated coverage losses due to policies that take effect in CY 2026 alone.
- **Provide an additional 0.30% to support hospital readiness for H.R.1 and AHEAD.** To support statewide efforts to mitigate Medicaid coverage losses under H.R.1, hospitals will need additional resources to identify and enroll Medicaid-eligible patients, help them maintain coverage, and navigate payment processes. Hospitals will also need to make

significant investments to successfully operate under two different sets of payment policies and regulatory systems under AHEAD.

- **Discontinue the productivity adjustment for non-GBR hospitals.** The proposed 0.80% adjustment would leave non-GBR hospitals less equipped to manage cost pressures and could unintentionally limit capacity. The provision of the full inflation allowance (3.37%) will help protect access to specialty care.

The state's favorable Medicare total cost of care (TCOC) savings performance through CY 2025 and recent United States Per Capita Cost (USPCC) trend projections enable HSCRC to provide the funding needed to preserve access to care and address hospital needs while preserving the state's ability to meet its commitments under AHEAD, as further described in *Appendix 1*.

\*\*\*\*\*

### **Inflation**

MHA supports the proposed inflation increase of 3.37% included in the draft recommendation. This includes a 3.17% core inflation allowance based on S&P Global's estimates from Q4 2025 and a 0.20% correction of historical cumulative underfunding in accordance with the revised "inflation catch-up" policy approved by the Commission last July. A sufficient inflation allowance ensures hospitals can continue to meet the care needs of their communities in an increasingly costly operating environment by helping hospital rates and global budget revenue keep pace with rising labor, supply, and operating costs that are largely outside of their control.

Economic volatility, particularly in energy markets, could place significant pressure on hospital operating costs. Increases in natural gas and electricity prices present a unique challenge for hospitals given their need to keep their doors open and lights on 24/7/365. These costs are especially burdensome for hospitals with aging infrastructure and insufficient capital to upgrade their facilities. Instability in energy markets and large price swings may also have ripple effects for the medical supply chain and transportation, which would place added cost pressure on hospital operations. Given this volatility and considering that regional energy prices have grown at a faster rate than the nation in recent years, it will be important for HSCRC to continue to closely monitor inflation throughout the upcoming year to ensure the allowance included in the update factor is adequate.

### **Uncompensated Care**

The current uncompensated care provision in rates is historically low. While the RY 2027 provision will be updated based on RY 2025 data, the resulting level of rate support will not be aligned with the UCC burden hospitals will face in the upcoming year due to the impacts of H.R.1 and other federal policy changes. In anticipation of a large decrease in UCC due to expanded coverage under the Affordable Care Act, HSCRC modified the policy in 2014, resulting in a prospective decrease in UCC rate support for RY 2015 (see *Appendix 2*).<sup>1</sup> Now, as the state confronts the potential for a sizeable increase in UCC as a result of significant Medicaid and Marketplace coverage losses, HSCRC should take similar action. MHA respectfully urges

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<sup>1</sup> As noted in HSCRC's Rate Year 2026 Uncompensated Care Report from November 2025, "In anticipation of large decreases in UCC in 2014, HSCRC adjusted their policy to avoid carrying over higher UCC amounts".

HSCRC to prospectively adjust the UCC provision in rates by 0.69% in RY 2027, based on an analysis of state-estimated coverage losses due to policy changes that take effect in CY 2026. Without a prospective adjustment, any increase in UCC in RY 2027 would not be reflected in rates until RY 2029 under the current policy, which would place further financial strain on hospitals and threaten their ability to preserve access to essential acute care in the interim.

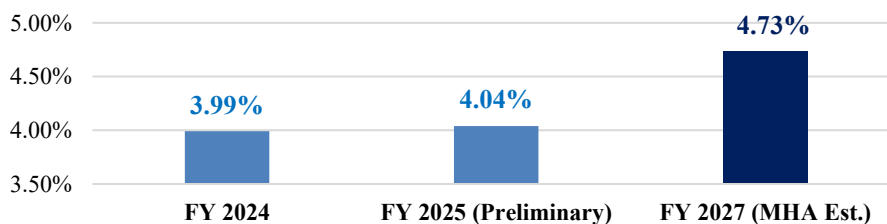
*Estimated Medicaid and Marketplace Coverage Losses*

Significant reductions in Medicaid enrollment are expected under H.R. 1 as new work requirements, six-month eligibility redeterminations, changes to immigrant eligibility, and other provisions take effect. As many as 130,000 Marylanders could lose Medicaid coverage due to H.R.1, according to the Maryland Department of Health (MDH). Other estimates from the Kaiser Family Foundation (KFF) and the RAND Corporation (180,000 and 230,000, respectively) project even higher coverage losses in Maryland.<sup>2, 3, 4</sup> At the same time, the expiration of federal enhanced premium tax credits and changes to immigrant eligibility for tax credits for ACA Marketplace plans—two changes that took effect in January 2026—could reduce Maryland Health Connection (MHC) enrollment by 50,000, according to estimates from the Maryland Health Benefit Exchange (MHBE).<sup>1</sup> See *Appendix 3* for a summary of notable policy changes impacting enrollment and a comparison of associated coverage loss estimates.

*Prospective Adjustment to UCC Provision in Rates*

MHA’s analysis suggests the need for a 0.69% prospective UCC adjustment for RY 2027, which would raise the statewide UCC provision in rates to 4.73% (see *Figure 1*).<sup>5</sup> This estimate is based on a fraction of the state projected coverage losses, specifically those tied to policy changes that take effect in CY 2026. These include changes to immigrant eligibility for Medicaid coverage and Marketplace tax credits, as well as the expiration of federal enhanced premium tax credits (ePTCs), totaling 65,000 projected coverage losses. The actual increase in UCC could exceed 0.69% if additional coverage losses result from policy changes taking effect in CY 2027 that were not captured in MHA’s analysis.

**Figure 1. Statewide UCC Pool, MHA Estimate**



Source: RE schedule, FY 2025 + FY 2024 for December hospitals

<sup>2</sup> Maryland Department of Health and Maryland Health Benefit Exchange January 20, 2026 Briefing to the House Appropriations Committee on H.R.1. Available [here](#). MHBE presentation starts on slide 42, MDH on slide 69.

<sup>3</sup> Kaiser Family Foundation. August 20, 2025. How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State: Allocating CBO’s Estimates of Additional Uninsured People Across the States. Available [here](#).

<sup>4</sup> RAND. February 26, 2026. State-Level Impacts of Key Medicaid Provisions in the OBBA. Available [here](#).

<sup>5</sup> MHA calculated the 0.69% projected increase in UCC by multiplying the projected coverage loss of 65,000 by the average cost per uninsured (\$2,380) based on the total amount of UCC in RY 2025 (approx. \$901 million) and the number of uninsured individuals statewide (378,600).

While Medicaid policy changes will not take effect until later this year or in 2027, questions remain about the effectiveness of the mitigation strategies outlined in the draft recommendation. The impacts of Marketplace policy changes, however, are already beginning to emerge.

Recent MHBE data show that 33,000 fewer individuals were enrolled in coverage through Maryland Health Connection (MHC) as of April 2026 compared to the start of the plan year, a 13% decrease compared to the 4% decline in enrollment as of April 2025.<sup>6, 7</sup> At the same time, those who are enrolling are downgrading coverage, opting for lower-premium bronze plans with up to \$10,000 deductibles. Enrollment in bronze plans as of April 2026 was 7% higher than 2025 levels, whereas enrollment in all other standard metal tiers declined year-over-year: silver (-7%), gold (-16%), and platinum (-39%).<sup>6</sup> These challenging enrollment trends have occurred despite the availability of state subsidies for plan year 2026 that have lowered monthly premiums by an average of \$95 for nearly seven in 10 MHC consumers. These trends could persist or worsen in plan year 2027 with subsidies that will likely be less generous.<sup>8</sup>

### **Hospital Readiness for H.R.1 and AHEAD**

In preparation for the projected rise in uninsured patients due to H.R.1 Medicaid changes, hospitals will need to make significant operational changes to be ready to support statewide efforts to maximize enrollment in Medicaid. At the same time, hospitals will be making significant investments in staffing, training, and other operational capabilities to prepare for the transition to bifurcated AHEAD policies and programs. MHA urges HSCRC to allocate an additional 0.20% for H.R.1 preparation and 0.10% for AHEAD Model implementation. HSCRC should consider reallocating the Healthcare Outcome Payment Effort (HOPE) funding to support these important statewide priorities.

Under the new coverage environment, hospitals will need to hire additional financial counselors to conduct more extensive Medicaid eligibility screenings, assist with Medicaid applications, assist with more frequent re-enrollment processes, and increase outreach to patients who lose coverage due to procedural or administrative barriers. In addition to expanding front-end capacity, hospitals must strengthen their revenue cycle resources to navigate the new policy changes and coverage landscape. Medicaid eligibility churn, shorter retroactive coverage periods, and more frequent procedural disenrollments are likely to increase denied claims due to coverage lapses or missing documentation. This will create additional administrative burden for hospitals that already dedicate significant resources to securing reimbursement for the care they provide to Medicaid patients.

These coverage disruptions, along with the increased volume of uninsured patients, will not be temporary. Hospitals will need to permanently expand these capabilities to manage these challenges, rather than treat them as short-term response to a policy transition.

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<sup>6</sup> Maryland Health Benefit Exchange. Maryland Health Connection Enrollment Data Dashboard. Available [here](#).

<sup>7</sup> Enrollment declined by more than 18,000 from March to April, likely due to the expiration of grace periods for non-payment of premiums.

<sup>8</sup> At MHBE's April Board meeting, the Board approved MHBE staff's preliminary proposal for the parameters for the 2027 state subsidy program. MHBE's Board will be asked to vote on the final proposed parameters in July.

The transition to AHEAD policies and programs is unprecedented and resource intensive for hospitals. For decades, Maryland's unique all-payer global budget revenue system has been built on consistent policies across payers. AHEAD represents a significant departure from that long-standing approach.

Starting in 2028, hospitals will operate under two payment policies and regulatory systems—one for Medicare and another for Medicaid and commercial payers—adding complexity to an already complicated system. As part of their efforts to effectively plan for the transition to this bifurcated system, hospitals will need to allocate significant additional resources to their finance and revenue cycle, clinical operations, quality, and technology workstreams. The AHEAD Model will require hospitals to hire new staff and train existing staff to optimize Medicare cost reporting, transition to a diagnosis-based billing system (i.e., MS-DRG), enhance clinical documentation improvement (CDI), reconfigure systems, and prepare for new payment routines with the Centers for Medicare & Medicaid Services (CMS). Hospitals will also need to assess national quality programs, align systems to manage multiple quality programs by payer, and make investments in productivity management tools and other technology system upgrades, among other planning activities.

### **Productivity Adjustment**

In their draft recommendation, staff propose a 0.80% productivity adjustment to the inflation allowance for non-GBR hospitals. MHA recommends HSCRC discontinue the productivity adjustment and provide specialty hospitals with the full inflation allowance included in the draft recommendation (3.37%). The adjustment is intended to promote cost control and efficiency in operations at non-GBR hospitals. However, it fails to recognize the operational realities of Maryland's specialty hospitals and undermines their ability to preserve access to critical specialty services.

Specialty hospitals play a critical role in Maryland's health care continuum, serving some of the state's most vulnerable populations who cannot safely or effectively be cared for elsewhere. They provide unique inpatient and outpatient behavioral health and pediatric post-acute services to clinically complex patients. This requires specialized nurses, physicians, social workers and other caregivers, often with higher staffing ratios than general acute care hospitals. Given the complexity and highly labor intensive nature of the care they provide, these hospitals cannot be expected to make gains in efficiency without compromising care quality and patient safety.

The productivity adjustment assumes specialty hospitals can and will drive volumes. However, volumes at these hospitals either remain relatively low or are limited by provider and capacity constraints. They do not benefit from the predictability of the GBR system, making them more susceptible to financial challenges due to fluctuations in utilization or operating cost growth. Furthermore, these hospitals face the same cost pressures as their GBR counterparts, including rising energy and staffing costs. However, they are less equipped to absorb these pressures after several years of lower inflation allowances and low reimbursement rates relative to costs. Reinstating the productivity adjustment in RY 2027 would continue this payment inequity. It would also place non-GBR hospitals at a disadvantage in recruiting and retaining the specialized staff required to meet the needs of their patients at a time when they are experiencing clinical workforce shortages.

**Conclusion**

MHA appreciates the time and effort HSCRC staff have dedicated to the draft recommendation for the RY 2027 update and welcomes the opportunity to work with Commissioners and staff to develop the final recommendation in June. In the coming year, hospitals will need to manage rising input costs due to economic volatility, a higher number of uninsured patients due to federal policy changes, and prepare for AHEAD policies and programs—all while continuing to provide high-quality care to their communities. We ask the Commission to ensure hospitals have sufficient resources for operational readiness and necessary investment in RY 2027, while protecting their long-term financial sustainability.

Thank you for the opportunity to comment on this important matter. If you have any questions, please do not hesitate to contact me.

Sincerely,



Melony G. Griffith  
President & CEO

cc: Dr. Joshua Sharfstein, Chair  
Jonathan Blum  
Dr. James Elliot  
Ricardo Johnson  
Dr. David Maine  
Nicki McCann  
Dr. Farzaneh Sabi  
Cait Cooksey  
Jerry Schmith  
William Henderson

## Appendix 1. Funding Capacity

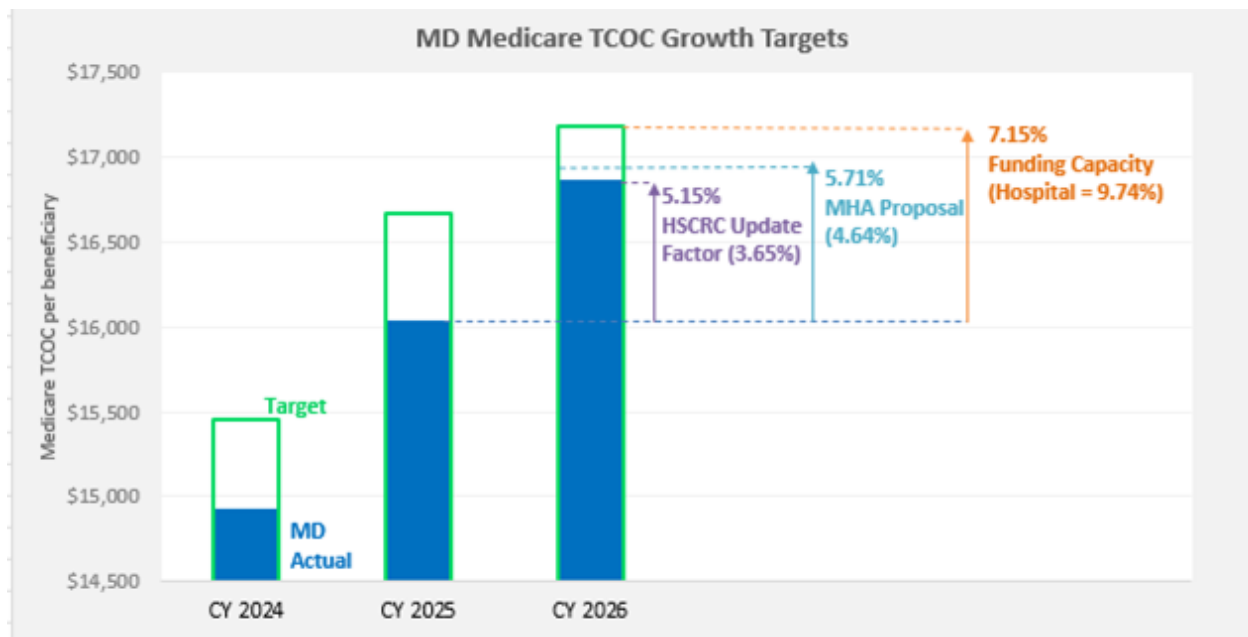
In its draft recommendation, staff present two scenarios for AHEAD target growth rates based on national USPCC trends:

- **Scenario 1:** The 2026 annual target is 4.0 percent, with cumulative growth of 19.0 percent since 2023, based on published USPCC rates.
- **Scenario 2:** Adjusts the national trend by removing duplicate CMS payment adjustments for indirect medical education (IME) and direct graduate medical education (DGME). If these corrections are made, the 2026 annual target increases to 5.3 percent, with cumulative growth of 22.2 percent.

Because AHEAD targets are intended to reflect actual Medicare fee-for-service (FFS) trends as measured by USPCC, MHA believes adjusting the trend for these IME and DGME payments is necessary to ensure a valid and fair comparison of Maryland's performance to national trends.

Using Scenario 2 targets and incorporating Maryland's performance in 2024 and 2025, MHA estimates that the maximum allowable total cost of care (TCOC) growth rate for 2026 is 7.15 percent. Assuming non-hospital spending grows at the national projected rate of 5.21 percent, this implies a hospital revenue per beneficiary growth capacity of approximately 9.74 percent (Figure A.1).

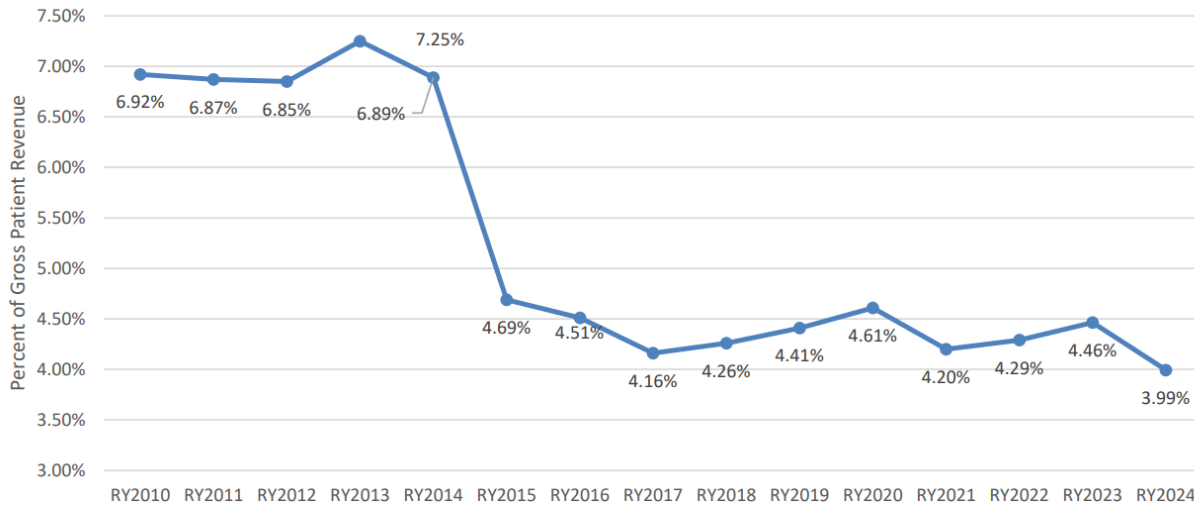
**Figure A.1. Maryland Funding Capacity, MHA Estimate  
Based on HSCRC Scenario 2 Modeling Estimates**



MHA proposal (4.64%) includes draft recommendation (3.65%) + UCC (0.69%) + Hospital Readiness (0.30%)

## Appendix 2. Uncompensated Care

**Actual Statewide UCC in Rates (RY 2010 – RY 2024)**



*“Before ACA, HSCRC based the Actual UCC included in pool funding calculations on a 3-year rolling average. This smooths the year over year hospital-specific changes in UCC. **In anticipation of large decreases in UCC in 2014, HSCRC adjusted their policy to use 1 year of data, to avoid carrying over higher UCC amounts.**”*

Source: HSCRC Rate Year 2026 Uncompensated Care Report, November 3, 2025

### Appendix 3. H.R.1 and Other Federal Policy Changes

**Table 1. Key Policy Changes, Estimated Coverage Losses, and Impact on RY27 UCC**

Provision – <i>Effective Date</i>	State Estimated Coverage Loss	Included in 0.69% Prospective Adj.
<i>Marketplace Policy Changes</i>		
<b>Immigrant Eligibility for Tax Credits</b> – <i>Effective 1/1/26</i> Ends eligibility for Marketplace premium tax credits for lawfully present immigrants under 100% FPL.	20,000	Yes
<b>Enhanced Premium Tax Credits (ePTCs)</b> – <i>Effective 1/1/26</i> Ends federal Affordable Care Act enhanced premium tax credits made available via the American Rescue Plan Act.	30,000	Yes
<i>Medicaid Policy Changes</i>		
<b>Immigrant Eligibility Changes</b> – <i>Effective 10/1/26</i> Limits Medicaid and CHIP eligibility to lawful permanent residents, certain Cuban and Haitian entrants, and individuals from the Compacts of Free Association nations. Excludes refugees, asylees, and other humanitarian groups.	15,000	Yes
<b>Work Requirements</b> – <i>Effective 1/1/27*</i> Requires certain expansion adults to complete 80 hrs. per month of work, education, or community service as a condition of eligibility. Applies to individuals ages 19-64, with limited exemptions and must be verified through ex-parte processes.	115,000	No
<b>Six-Month Redeterminations</b> – <i>Effective 1/1/27</i> Requires Medicaid eligibility redeterminations every six months for adult expansion enrollees or those receiving Minimum Essential Coverage (MEC) through a waiver.	--	No
<b>Retroactive Coverage</b> – <i>Effective 1/1/27</i> Reduces retroactive coverage from three months to one month for expansion adults and two months for all other groups.	--	No

\* States can request good faith effort extensions through December 31, 2028

Sources: Maryland Department of Health and Maryland Health Benefit Exchange Jan. 20, 2026 Briefing to the House Appropriations Committee on H.R.1. Available [here](#). MHBE presentation starts on slide 42, MDH on slide 69.

**Table 2. Comparison of Medicaid and Marketplace Coverage Loss Estimates**

	MDH/MHBE	KFF	RAND
<b>Medicaid</b>	130,000	180,000 (140,000 – 230,000)	230,000
<b>Marketplace</b>	50,000	30,000	--
<b>Total</b>	<b>180,000</b>	<b>210,000</b> (160,000 – 260,000)	<b>230,000</b>

Sources: same as above (MDH/MHBE) and footnotes 2 (KFF), and 3 (RAND) on pg. 3



May 20, 2026

Dr. Jon Kromm  
Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Dr. Kromm:

Adventist HealthCare appreciates the opportunity to comment on the Health Services Cost Review Commission (HSCRC) Draft Recommendation for the Update Factor for Rate Year 2027. We are supportive of the Maryland Hospital Association's position on the update factor and would like to share several additional considerations that we believe warrant the Commission's attention. Specifically, Adventist HealthCare respectfully requests that the Commission: (1) distribute the national demand modifier proportionally based on age-adjusted demographic growth; (2) ensure the Healthcare Outcome Payment Effort (HOPE) does not disadvantage already efficient, low-total-cost-of-care regions and does not proceed before access and latent-demand issues are addressed; (3) provide the additional 0.30% hospital readiness adjustment recommended by MHA; (4) prospectively adjust the uncompensated care provision by 0.69%. We offer these comments in the spirit of partnership and in recognition of the considerable work HSCRC staff have invested in this important recommendation.

### **National Demand Modifier Distribution**

The Commission's approach to spreading the 0.1% national demand modifier presents a significant equity concern that merits reconsideration. The current methodology distributes this adjustment evenly across all hospitals in the state, regardless of the actual concentration of aging populations or their demographic characteristics by region. This approach creates a disconnect between the purpose of the adjustment and its distribution because hospitals with materially different demographic pressures receive the same statewide allocation.

The issue is particularly acute for hospitals experiencing substantial population aging in their service areas. For example, White Oak Medical Center faces population-adjusted growth of over 11% to its aging population yet receives only 0.1% of the national demand modifier, the same as hospitals experiencing negative adjustments. This creates a fundamental misalignment between the policy's purpose and its implementation.

Since the broader HSCRC funding framework allocates the majority of population-based funding according to regional concentration of age and population growth, **we recommend that the national demand modifier be distributed proportionally using the same methodology.** Doing so would ensure that funding



targeted at the fiscal impacts of aging is directed to the areas of the state experiencing the greatest demographic pressure, thereby better serving Maryland's most vulnerable aging populations.

### **Healthcare Outcome Payment Effort (HOPE) Framework**

Adventist HealthCare supports the intent of the HOPE framework to reduce total cost of care while maintaining and improving clinical quality outcomes. However, we have significant concerns about the current policy design that should be addressed before implementation.

First, the improvement-only methodology creates an inequitable outcome for hospitals and regions that already operate at historically low cost levels. Some areas of Maryland, including Montgomery County where two of our hospitals are located, already rank among the lowest TCOC counties in both the state and the nation. Hospitals in these regions will have limited access to HOPE funding through no fault of their own, but rather because they are already performing at high efficiency. This policy design inadvertently penalizes high-performing communities. HSCRC should include a mechanism for high-performing, low-TCOC hospitals to qualify based on maintaining efficient performance, not only improving from baseline.

Second, the Commission has not yet conducted a comprehensive assessment of latent demand or care access across the state. Low utilization rates in some areas may reflect genuine efficiency, but they may alternatively reflect unmet need for medically necessary care. Before implementing a policy that restricts funding based on TCOC performance alone, the Commission should establish an explicit framework to assess whether adequate care access exists, particularly in lower-TCOC regions. Without this assessment, the state risks restricting resources in areas that may actually have capacity or access deficiencies. Accordingly, HSCRC should not finalize HOPE until latent-demand and access issues are explicitly addressed.

Third, we respectfully recommend that HSCRC explicitly coordinate approval with the Centers for Medicare & Medicaid Services (CMMI) before finalizing the HOPE policy. The complexity of operating under parallel AHEAD payment policies, combined with the administrative burden of managing overlapping regulatory systems, requires CMMI's active participation in policy design to ensure alignment and operational feasibility.

**Adventist HealthCare respectfully recommends that HOPE implementation be delayed until the above concerns, including explicit assessment of latent demand and access and CMMI coordination, are adequately addressed.** The 0.21% of funding currently allocated to HOPE could instead be redeployed to address more immediate funding needs, including AHEAD readiness investments and uncompensated care increases.

### **Hospital Readiness Funding for AHEAD Transition**

We appreciate the Commission's recognition that hospitals require additional resources to prepare for the January 2028 AHEAD transition. However, the funding provided to date is insufficient to support the operational readiness necessary for this unprecedented transition.



For Adventist HealthCare, the January 2025 AHEAD funding allocation was approximately \$2.2 million against a revenue base of approximately \$1 billion. After accounting for the cash collection cycle and accounting for differential reimbursement, denials, and bad debt, the net funding available for operations is approximately \$1.8 million. This funding has been directed primarily toward addressing structural deficits created by cumulative underfunding of demographic and inflation adjustments over several years. As of the end of 2025, Adventist accumulated a \$20 million structural deficit in compensation while attempting to maintain break-even operations.

Adventist is also already incurring costs to prepare for AHEAD, including licensing and implementation of MS-DRG grouping software, training and hiring of additional documentation specialists and coders, restructuring of quality programs to align with CMS quality metrics, and system reconfiguration for Medicare cost reporting. **We therefore respectfully urge the Commission to allocate an additional 0.30% for hospital readiness as recommended by the Maryland Hospital Association, which would provide hospitals with meaningful resources to execute their transition planning.**

### **Uncompensated Care and Marketplace Coverage Disruptions**

We concur with HSCRC staff that the primary impacts of H.R.1's *Medicaid* provisions will not be fully realized until later in 2026 and 2027. However, we respectfully note that hospitals are experiencing significant uncompensated care pressure from current federal policy changes affecting the Marketplace, and this warrants near-term policy attention.

The most recent Maryland Health Benefit Exchange data show that enrollment in Maryland Health Connection declined by 33,000 individuals (a 13% decrease) from the start of the plan year through April 2026, compared to a 4% decline in the prior year. Concurrently, approximately 8,000 enrollees shifted from gold plans to bronze plans with deductibles as high as \$10,000, which significantly increases exposure to bad debt and charity care in the hospital setting. These trends represent immediate and measurable impacts on hospital uncompensated care that are occurring now, not in the future.

Under the current uncompensated care policy, any increase in UCC in rate year 2027 will not be reflected in rates until rate year 2029. A two-year lag is operationally untenable for hospitals managing active cash flow challenges. **We therefore support the Maryland Hospital Association's recommendation for a prospective 0.69% adjustment to the uncompensated care provision for rate year 2027, based on state-estimated coverage losses from federal policy changes taking effect in calendar year 2026.**

### **Conclusion**

Adventist HealthCare appreciates the Commission's continued commitment to partnering with Maryland hospitals and acknowledges the significant effort HSCRC staff have invested in developing this comprehensive recommendation. We believe these targeted modifications can be made while maintaining Maryland's ability to meet its AHEAD commitments. We look forward to working collaboratively with the Commission through the June finalization process to address these important considerations. Please feel free to contact me if you would like to discuss any of these points further.



**Adventist HealthCare's Recommendations**

1. **Demographic:** Distribute the national demand modifier proportionally based on age-adjusted demographic growth in each region, ensuring that funding targeted at aging population impacts is directed to areas experiencing the greatest demographic pressure.
2. **HOPE:** Delay implementation of the Healthcare Outcome Payment Effort (HOPE) framework until the Commission conducts a comprehensive assessment of latent demand and care access, includes a mechanism for high-performing low-TCOC hospitals to qualify based on maintaining efficient performance, and explicitly coordinates with the Centers for Medicare & Medicaid Services (CMMI).
3. **AHEAD Readiness:** Allocate the additional 0.30% for hospital readiness as recommended by the Maryland Hospital Association, providing hospitals with meaningful capacity to execute AHEAD transition planning and manage the operational complexities of this unprecedented transition.
4. **Uncompensated Care:** Prospectively adjust the uncompensated care provision by 0.69% for rate year 2027 based on state-estimated coverage losses from federal policy changes taking effect in calendar year 2026, eliminating the operationally untenable two-year lag in current policy.

Sincerely,



Katie Eckert, CPA  
Senior Vice President, Strategic Operations  
Adventist HealthCare

cc: Dr. Joshua Sharfstein, Chair  
Jonathan Blum  
Dr. James Elliott  
Ricardo Johnson  
Dr. David Maine  
Nicki McCann  
Dr. Farzaneh Sabi  
Cait Cooksey  
Jerry Schmith  
William Henderson





May 20, 2026

Dr. Jon Kromm

Executive Director

Health Services Cost Review Commission (HSCRC)

4160 Patterson Avenue Baltimore, MD 21215

**Re: RY 2027 Update Factor Recommendation**

Dr. Jon Kromm and HSCRC Commissioners:

Health Means Everything (HME) appreciates the opportunity to comment on the draft recommendation of the Update Factor for Rate Year (RY) 2027. While we understand this update is designed to provide hospitals with reasonable rate adjustments to address issues such as inflation and maintain operational readiness, we are concerned about the rising cost of health care and how changes to the update factor may exacerbate health care affordability challenges for consumers in the State. HME appreciates the HSCRC's consideration of the many factors that can impact the cost of delivering health care services, but we are concerned that the continuous rate increases hospitals receive year-over-year impose additional unnecessary burdens on consumers.

We worry that the continued divergence of hospital revenues and the ability of Marylanders to afford their health care is reaching a critical point. Since the year 2000, prices for hospital services in the US have increased 271.1%, outpacing other goods and services categories as well as average hourly wages (see Figure 1).<sup>1</sup> Consumers have had to find ways to manage increases in the price of medical services, childcare, and college tuition while hospitals have managed by increasing prices to not only cover costs, but to expand profits and build reserves. Over the past several years, hospital revenues have grown significantly. The RY 2025 update was approximately 4.8%, followed by a 5.68% revenue increase in RY 2026, and now a proposed 3.65% increase in RY 2027.<sup>2</sup> While we acknowledge that the proposed RY 2027 update is lower than last year, **the cumulative**

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<sup>1</sup> <https://humanprogress.org/time-pricing-mark-perrys-latest-chart-of-the-century/>

<sup>2</sup> <https://www.hmecalliance.com/rising-cost-of-care>

**effect of these increases compounds year over year.** Marylanders are not simply absorbing one year's increase, they are absorbing the weight of many consecutive years of growth in hospital costs, which flows directly into insurance premiums, cost-sharing, and out-of-pocket expenses.

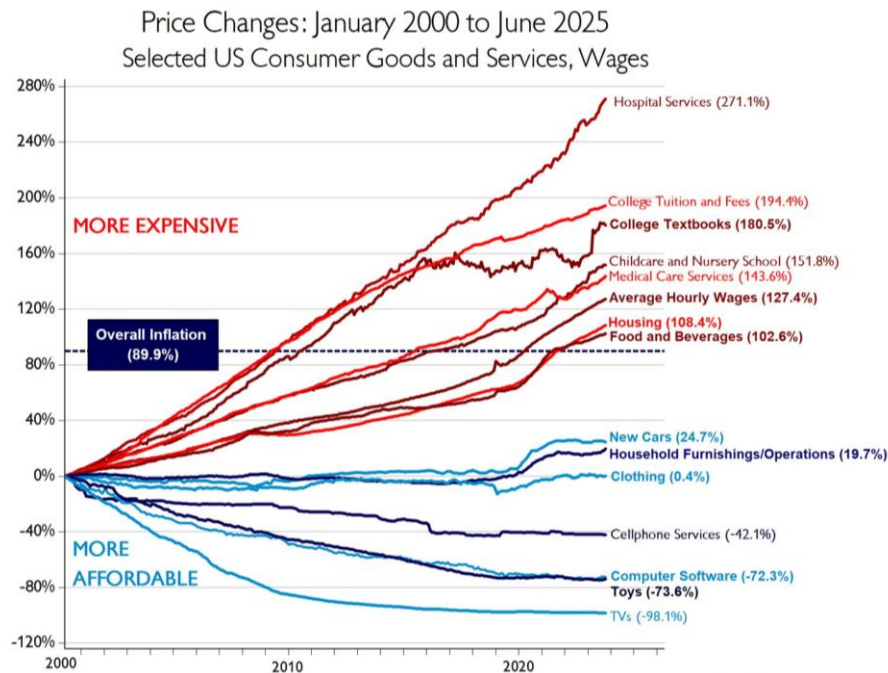


Figure 1. Trends in US Consumer Goods, Services, and Wages. Analysis by Mark J. Perry.  
Data Source: Bureau of Labor Statistics

HME’s core concern is that hospital revenue growth continues to outpace what average Marylanders can afford. Wage growth in Maryland has not kept pace with the rate at which hospital revenues have grown. According to the Bureau of Labor Statistics, average weekly wages in Maryland have grown at a modest rate in recent years, especially in rural areas, while hospital revenues under the HSCRC have consistently grown.<sup>3</sup> When the cost of health care rises faster than incomes, health insurance becomes less affordable, more Marylanders go uninsured or underinsured, and population health goals will become harder to reach.

**HME notes that the foundation of Maryland's all-payer system was rooted in the fact that hospital cost growth should not outpace economic growth.** In years prior, the Maryland All-Payer Model limited all-payer per capita hospital growth, including inpatient

<sup>3</sup> [https://www.bls.gov/regions/mid-atlantic/news-release/countyemploymentandwages\\_maryland.htm](https://www.bls.gov/regions/mid-atlantic/news-release/countyemploymentandwages_maryland.htm)

and outpatient care, to 3.58%.<sup>4</sup> While we understand that the Maryland model has undergone significant changes from the Total Cost of Care Model (TCoC) to now the AHEAD (Achieving Healthcare Efficiency through Accountable Design) Model, the commitment to keeping health care affordable for consumers has always been, and must remain a guiding principle of Maryland's approach to care. We ask the Commission to consider the real-world impact of these increases on consumers.

HME appreciates the Commission's commitment to balancing hospital financial considerations with the affordability of health care for all Marylanders, and the degree of thought and expertise that have been put into the HSCRC's recommended approach on this issue. We believe the HSCRC's recommendation as the industry's regulator should be treated as a cap on the potential increase under consideration, and that any potential for further increase be tabled as beyond the scope of consideration given the breadth and depth of the affordability crisis Maryland residents are currently subject to.

We appreciate the opportunity to offer comment on this subject, and look forward to continued engagement on these critical issues.

Thank you for your consideration,

Ashiah Parker  
Chair, Health Means Everything Consumer Alliance

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<sup>4</sup> <https://www.cms.gov/priorities/innovation/innovation-models/maryland-all-payer-model>

May 20, 2026

Dr. Jon Kromm  
Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Dr. Kromm:

Thank you for the opportunity to comment on the Health Services Cost Review Commission (HSCRC) Draft Recommendation for the Update Factor for Rate Year 2027. We appreciate the time staff have dedicated to ensuring a fair and reasonable update as well as their collaboration with stakeholders over the past several months on this important issue.

Frederick Health and all Maryland hospitals will be operating in a rapidly changing and challenging health care landscape in rate year 2027 with several policies refinement and development still in progress. The current economic environment, transition to bifurcated AHEAD Model policies, and federal policy changes impacting health coverage have added complexity and uncertainty at a time when many hospitals continue to confront financial challenges. Frederick Health supports the following MHA recommendations to strengthen the HSCRC update factor recommendation to preserve access to care, ensure hospitals have sufficient resources for operational readiness and necessary investment, and help facilitate a successful transition to AHEAD:

- **Monitor inflation throughout the rate year.** We support the staff recommendation to fully fund inflation of 3.37% which includes a 0.20% correction of historical cumulative underfunding in accordance with the revised “inflation catch-up” policy approved by the Commission last July. Additionally, as economic volatility and contemporary cost pressures, including high and rising energy prices, introduce uncertainty and potential inflationary impacts that may not be captured in current forecasts, we recommend staff monitor inflation throughout the year to ensure the inflation allowance is adequate.
- **Prospectively adjust the uncompensated care (UCC) provision in rates by 0.69%.** H.R. 1 and other federal policy changes are expected to result in significant Medicaid and Marketplace coverage losses. Reductions in Medicaid enrollment are expected under H.R. 1 as new work requirements, six-month eligibility redeterminations, changes to immigrant eligibility, and other provisions take effect. However, under HSCRC’s current

policy, increases in UCC in RY 2027 will not be reflected in rates until RY 2029. MHA has estimated UCC levels could increase to 4.73% in FY 2027 (a 0.69% increase over FY 2025), based on state-estimated coverage losses due to policies that take effect in CY 2026 alone. External analysis showed that Frederick could see as high as \$7M a year in reduced net reimbursement due to Medicaid disenrollment. Without a prospective adjustment, any increase in UCC in RY 2027 would not be reflected in rates until RY 2029 under the current policy, which would place further financial strain on Frederick Health and threaten our ability to preserve access to essential acute care in the interim.

- **Provide an additional 0.30% to support hospital readiness for H.R.1 and AHEAD (0.20% for H.R.1 preparation and 0.10% for AHEAD Model implementation).** In preparation for the projected rise in uninsured patients due to H.R.1 Medicaid changes, we will need to make operational changes to be ready to support statewide efforts to maximize enrollment in Medicaid. Under the new coverage environment, we will need to hire additional financial counselors to conduct more extensive Medicaid eligibility screenings, assist with Medicaid applications, assist with more frequent re-enrollment processes, and increase outreach to patients who lose coverage due to procedural or administrative barriers. Medicaid eligibility churn, shorter retroactive coverage periods, and more frequent procedural disenrollments are likely to increase denied claims due to coverage lapses or missing documentation. This will create additional administrative burden for Frederick to secure reimbursement for the care provided to Medicaid patients and will delay cash payment necessary to support hospital operations.

We appreciate the Commission's recognition that hospitals require additional resources to prepare for the January 2028 AHEAD transition. However, the funding provided to date is insufficient to support the operational readiness necessary for this unprecedented transition. Frederick Health will be making significant investments in staffing, training, and other operational capabilities to prepare for the transition to bifurcated AHEAD policies and programs. As part of our efforts to effectively plan for the transition to this bifurcated system, we will need to allocate significant additional resources to finance and revenue cycle, clinical operations, quality, and technology workstreams. The AHEAD Model will require us to hire new staff and train existing staff to optimize Medicare cost reporting, transition to a diagnosis-based billing system (i.e., MS-DRG), enhance clinical documentation improvement (CDI), reconfigure systems, and prepare for new payment routines with the Centers for Medicare & Medicaid Services (CMS). We will also need to assess national quality programs, align systems to manage multiple quality programs by payer, and make investments in productivity management tools and other technology system upgrades, among other planning activities.

- **Increase the Demographic Funding and prorate the National Demand Modifier.** In addition to MHA's recommendations, Frederick Health is requesting that the HSCRC increase the demographic funding. The current proposed FY2027 update factor includes 0.12% for volume funding related to population growth despite age adjusted growth of 8%. For Frederick the gap is even greater, age adjusted population growth is 17.7%

however Frederick Health will only receive 0.17% of demographic funding. The aging population is increasingly medically complex, with higher acuity and comorbidities. This trend results in increased demand for hospital services. Without adequate funding through the demographic adjustment increased volumes will be unfunded in the GBR.

The “national demand modifier” which was approved in January 2026 did not address the continued underfunding of volume growth due to the aging population. This underfunding comes at a time when it is critical to ensure hospitals have sufficient resources to meet growing community needs. In addition, the Commission's approach to spreading the 0.1% national demand modifier does not represent the true spread of age adjusted population growth across hospitals and gives every hospital the same 0.1%. This spread is regardless of the actual concentration of aging populations or their demographic characteristics by region. The issue is particularly acute for hospitals experiencing substantial population aging in their service areas. Frederick faces the highest population-adjusted growth of 17.7% to its aging population yet receives only 0.1% of the national demand modifier—the same 0.1% as the hospitals experiencing negative population growth. This creates a fundamental misalignment between the policy's purpose and its implementation.

We remain concerned that the current methodology does not sufficiently account for age-adjusted population growth as it caps the statewide adjustment at unadjusted population growth projections. For Frederick Health, the demographic adjustment is the only mechanism that provides additional revenue for expected utilization growth due to aging. As in prior years the gap between the age adjusted growth and the scaled adjustment provided is material for Frederick. While we agree that other factors can impact utilization it is not reasonable to assume that Frederick can absorb over 17% of expected volume growth. We request that the HSCRC increase the demographic funding in the FY2027 Update Factor to address the significant expected volume growth due to the aging of the population.

The state's favorable Medicare total cost of care (TCOC) savings performance through CY 2025 and recent United States Per Capita Cost (USPCC) trend projections enable HSCRC to provide the funding described above as needed to preserve access to care and address hospital needs while preserving the state's ability to meet its commitments under AHEAD.

Frederick Health appreciates the Commission's continued commitment to partnering with Maryland hospitals and acknowledges the significant effort HSCRC staff have invested in developing this comprehensive recommendation. We look forward to working collaboratively with the Commission to address these important considerations. Please feel free to contact me if you would like to discuss any of these points further.

Sincerely,



Hannah Jacobs  
Senior Vice President and CFO  
Frederick Health

cc: Dr. Joshua Sharfstein, Chair  
Jonathan Blum  
Dr. James Elliot  
Ricardo Johnson  
Dr. David Maine  
Nicki McCann  
Dr. Farzaneh Sabi  
Cait Cooksey  
Jerry Schmith  
William Henderson

May 20, 2026

Jon Kromm  
Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215



Dear Dr. Kromm:

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Draft Staff Recommendation for the Rate Year (RY) 2027 Payment Update.

JHHS supports the comments submitted by the Maryland Hospital Association (MHA). The recommendations outlined in MHA's letter reflect the operational and financial realities facing Maryland hospitals as they navigate a challenging and rapidly evolving environment, including sustained cost pressures, significant federal policy uncertainty, and the resource needs related to AHEAD Model transition. JHHS urges thoughtful consideration of MHA's recommendations when finalizing the RY27 update.

- 1. Monitor inflation throughout the rate year:** JHHS supports HSCRC staff's recommendation to fully fund inflation and agrees with MHA's call for ongoing monitoring throughout RY27. JHHS encourages the Commission to remain responsive to evolving cost conditions, particularly given the current market uncertainty and volatility.
- 2. Prospectively adjust the uncompensated care (UCC) provision in rates by 0.69%:** JHHS shares MHA's concern that the current uncompensated care (UCC) provision in rates will not be aligned with the burden hospitals are likely to face in the coming year. The coverage losses projected to result from H.R.1 and related federal policy changes, particularly those taking effect in CY26, are not reflected under the current policy framework. A prospective adjustment of 0.69%, consistent with MHA's analysis, is a reasonable and appropriate step to ensure hospitals are not left to absorb these costs without support in a time of transition. JHHS urges the Commission to implement this adjustment before realized impacts compound.
- 3. Provide an additional 0.30% to support hospital readiness for H.R.1 and AHEAD:** The demands of both preparing for projected coverage disruptions under H.R.1 and operationalizing AHEAD Model requirements will place significant resource strain on Maryland hospitals. JHHS is actively engaged in AHEAD transition planning and can attest to the substantial estimated investments required across clinical operations, finance, technology, and other workstreams to operate under a bifurcated payment model beginning in CY28. JHHS supports MHA's recommendation that the Commission provide an additional 0.30% to support these efforts.
- 4. Discontinue the productivity adjustment for non-GBR hospitals:** JHHS also supports MHA's recommendation to discontinue the productivity adjustment for non-GBR hospitals.





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**Susan K. Nelson**  
Executive Vice President and  
Chief Financial Officer

May 20, 2026

Dr. Jon Kromm  
Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Executive Director Kromm,

On behalf of MedStar Health and its seven Maryland hospitals, we appreciate the opportunity to comment on the Draft Recommendation for the Rate Year (RY) 2027 Update Factor. We commend HSCRC staff for their diligence during a period of exceptional complexity and uncertainty.

MedStar Health broadly supports the Maryland Hospital Association's (MHA) comments, including its requests related to fully funding the inflation allowance, prospectively adjusting the uncompensated care (UCC) provision, and providing additional resources for hospital readiness in light of H.R. 1 and the AHEAD Model transition. We write separately to underscore several concerns that are particularly acute for MedStar Health's Maryland hospitals and to advance one additional recommendation.

As a threshold matter, MedStar Health notes that Maryland's strong TCOC performance through CY 2025 and current USPCC trend projections provide meaningful fiscal capacity to support a more robust update than HSCRC staff have proposed. Using MHA's Scenario 2 modeling, which appropriately adjusts national trends for duplicate IME and DGME payment adjustments, Maryland has headroom to fund the full MHA proposal (4.64%) while preserving the state's ability to meet its AHEAD commitments. MedStar Health urges the Commission to provide this additional funding beyond the Staff's current recommendation at a moment when Maryland hospitals face simultaneous and compounding financial pressures.

#### **I. Maryland Hospital Financial Performance Lags the Nation, and Inflation Risks Remain Understated**

Maryland hospitals have underperformed national peers on key financial metrics since 2019. The cumulative effect of sustained rate pressure, below-trend inflation allowances, and pandemic-driven labor cost increases has left Maryland hospitals with limited financial resilience. MedStar Health fully supports funding the proposed 3.37% inflation allowance, but notes that this estimate is based on Q4 2025 forecasts and does not yet reflect inflationary pressures from the ongoing Middle East conflict, energy market volatility, or the potential impact of newly imposed tariffs on medical supplies and equipment. Hospitals operate around the clock; energy and supply costs are largely inelastic, and current inflation projections may prove inadequate.

Given the extraordinary volatility, MedStar Health would request consideration be given to suspend the inflation catch up methodology for one year, FY27, and provide the full underfunded inflation amount,

**It's how we treat people.**

providing hospitals an additional 0.25%. With the full transition to the AHEAD model looming, this additional unfunded inflation amount should be funded in FY27, or risks becoming a permanently unfunded amount.

Additionally, MedStar Health urges HSCRC to monitor inflation closely throughout RY 2027 and to make corrections if actual cost pressures exceed current forecasts. Given Maryland hospitals' already-strained financial position, there is little cushion to absorb unexpected cost increases without impacting access to care.

## **II. The AHEAD Transition Will Generate Substantial New Administrative Complexity and Cost**

Beginning in 2028, Maryland hospitals will operate simultaneously under two payment frameworks—one for Medicare and another for Medicaid and commercial payers. This bifurcated system will require meaningful new investments in staffing, CDI, revenue cycle infrastructure, quality reporting, and technology. These are not one-time transition costs; the ongoing complexity of managing two regulatory systems with distinct performance incentives and savings requirements will create a permanent increase in administrative burden.

MedStar Health supports MHA's request for an additional allocation to support AHEAD readiness. The Commission should treat this as an infrastructure investment. The operational and clinical groundwork required to meet AHEAD's escalating Medicare savings targets must begin now, and hospitals cannot absorb those costs without adequate rate support.

## **III. H.R. 1 Will Drive Significant Coverage Losses and Increased Hospital Costs That Must Be Recognized Now**

H.R. 1 initiated insurance coverage changes that will materially alter the patient mix at Maryland hospitals well before the end of RY 2027. HSCRC's current policy—under which increases in UCC are not reflected in rates until two years later—is inadequate to address the scale and immediacy of this disruption. Insurers in Maryland, recognizing the effects of H.R.1 on their own operations and their scale, have already filed for received approval for double digit percentage increases to premium rates in plan year 2026 & 2027 in order to pass on these costs to consumers. The HSCRC must take action to recognize the immediate impacts on hospitals in a similar manner. MedStar Health supports MHA's request for a prospective 0.69% UCC adjustment and an additional readiness allocation, and highlights the following specific impacts:

- Significant increases in uncompensated care as an estimated 130,000 to 230,000 Marylanders lose Medicaid coverage and tens of thousands more lose Marketplace coverage. MHBE enrollment data already show meaningful declines, with 33,000 fewer individuals enrolled as of April 2026 compared to the start of the plan year.
- A documented shift toward high-deductible bronze plans by approximately 8,000 former gold-plan enrollees, increasing bad debt exposure for hospitals.
- Permanent increases in administrative costs associated with Medicaid eligibility screenings, re-enrollment support, managing shorter retroactive coverage periods, and a higher volume of denied claims.

These are structural, not transitional, burdens. It should be noted that a prospective UCC adjustment is not unprecedented. HSCRC approved a prospective UCC reduction as a result of Medicaid Expansion, when hospital UCC amounts were anticipated to decrease as a result of additional Medicaid coverage. Funding this anticipated UCC increase for FY27 is a mirror image of the Medicaid Expansion issue and should be handled in a similar manner.

#### **IV. The Retrospective Elimination of CTI Undermines Hospital Confidence in Care Transformation—HSCRC Must Act to Restore It**

MedStar Health raises a concern on this final point that is distinct from MHA's submission and goes to the heart of HSCRC's ability to advance care transformation under AHEAD. At the May public meeting, the Commission voted to eliminate the rewards and penalties that the CTI program calculated based on FY25 performance due to the significant unintended consequences of the inclusion of geographic CTIs and their interaction with the net zero nature of the program.

The Care Transformation Initiative (CTI) was designed to reward hospitals that generated real, sustained savings through care redesign and clinical integration. MedStar Health's Maryland hospitals invested substantially in these programs—dedicating staff, infrastructure, and clinical leadership—and reinvested CTI rewards directly into the care coordinators, community health workers, and transitional care infrastructure. The retrospective elimination of the CTI program leaves hospitals with programs generating real savings with an abrupt funding gap with no clear transition mechanism.

The implications extend well beyond the immediate budget impact. AHEAD's success depends on hospitals' willingness to invest in care transformation—population health, care coordination, clinical integration—knowing that the financial incentives associated with those investments are reliable. If HSCRC eliminates earned rewards retroactively, it sends a signal to every Maryland hospital that care transformation investment is not worth the risk. That is precisely the wrong signal at this moment.

MedStar Health urges the Commission to use a portion of the approximately \$100 million in set-aside funds to provide bridge funding through at least FY 2028 to hospitals that: (1) had established high-performing CTI programs with consistent performance in multiple years; and (2) were projected to receive CTI rewards based on consistent savings generation.

#### **Conclusion**

MedStar Health is committed to improving the health of Marylanders and working in collaboration with the HSCRC and other stakeholders to develop and refine policies under the AHEAD Model that accomplish this goal. Maryland's strong TCOC performance provides the fiscal capacity to do more than the draft recommendation proposes—and the financial pressures confronting hospitals in RY 2027 demand it. We respectfully urge the Commission to fully fund the inflation allowance, prospectively adjust the UCC provision, provide readiness resources for H.R. 1 and AHEAD, and take corrective action on the retrospective elimination of CTI to restore the trust that effective care transformation requires.

We appreciate the Commission's consideration and welcome the opportunity to discuss any of these issues further.

Sincerely,



Susan K. Nelson

Executive Vice President and Chief Financial Officer, MedStar Health

cc: Joshua Sharfstein, MD      David N. Maine, MD  
James Elliott, MD      Nicki McCann, JD  
Jonathon Blum, MPP      Farzaneh Sabi, MD  
Ricardo R. Johnson

May 20, 2026

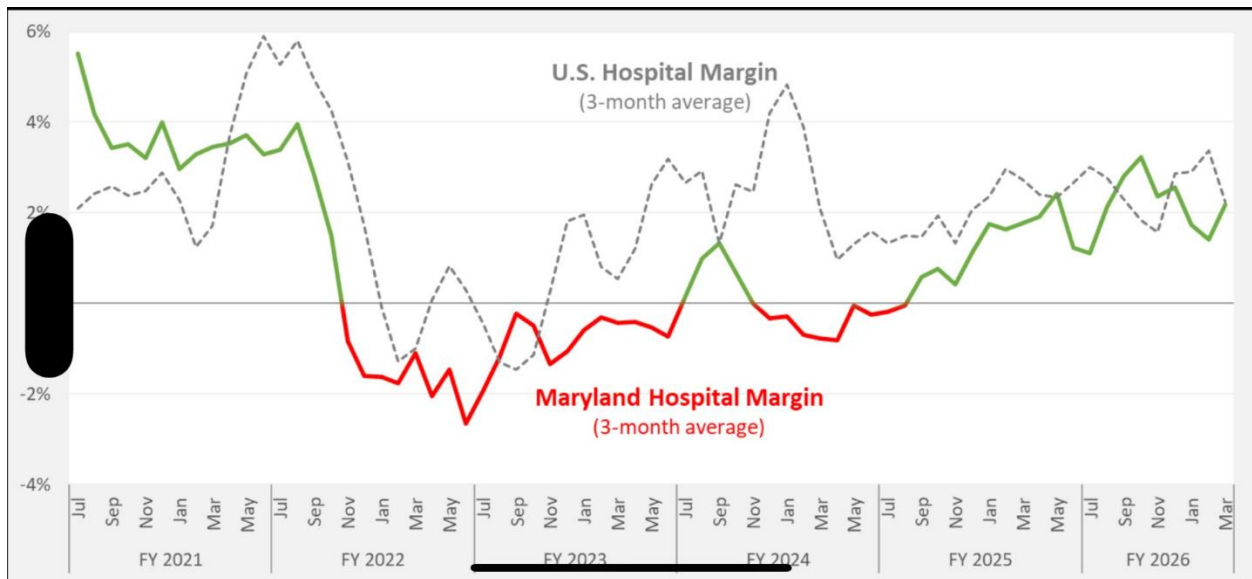
Jon Kromm, PhD Executive Director  
 Health Services Cost Review Commission  
 4160 Patterson Avenue  
 Baltimore, MD 21215

Dear Dr. Kromm,

I am writing on behalf of Luminis Health to provide comments on the Health Services Cost Review Commission staff's ("HSCRC") draft recommendation for the annual update factor for rate year 2027.

As we are in the beginning of the AHEAD model, it is critically important we have a strong financial foundation and that the update factor recognizes not only inflation growth but recognizes and appropriately funds for federal and local changes that impact our unique global budget system.

While Maryland Hospitals are showing improvements to overall financial performance, the state health systems FY26 operating margins continue to be below the nation.



Source: Maryland Hospital Association

Furthermore, the HSCRC provided one-time money in FY26 that elevated operating performance. These adjustments related to prior year demographic and uncompensated care corrections will be removed in FY27 eroding these operating margins. While we are extremely appreciative of the corrections and the funding, the current proposed update factor will have revenue growth from FY26 well below inflation for many Maryland Hospitals, including Luminis Health, when the one-time funding is removed. The removal of these dollars we believe are not included in the update factor projections. This challenge coupled with aging population growth, implementation of H.R.1. and the transition to the AHEAD Model creates financial instability and challenges for FY27.

Luminis Health has the following enhancements to the HSCRC staff recommendation to assist in creating financial stabilization:

**Support MHA’s Recommendation**

*(1) Inflation Funding Support with Monitoring and Permanent Removal of Specialty Hospital Productivity Adjustment*

Luminis Health supports the proposed 3.37% inflation increase included in the staff recommendation based on S&P Global estimates that include an additional 0.20% catch-up adjustment intended to address prior years of underfunding. As financial pressures continue to intensify across the healthcare sector, maintaining an adequate inflation update is essential to preserving access, stability, and quality of care throughout Maryland’s health system.

In addition, consistent with the letter submitted by Luminis Health to HSCRC on April 29, we request the indefinite suspension of the productivity adjustment for specialty hospitals. A productivity adjustment of 0.8% would reduce the inflation update to only 2.5% for hospitals that are serving some of our communities’ most vulnerable populations, despite these providers facing the same financial pressures as acute care hospitals. Specialty hospitals play a critical role in Maryland’s healthcare system, supporting the State’s priorities, and limiting funding for services with historically low reimbursement could potentially undermine access to critically necessary care.

We recommend monitoring inflation throughout the year to ensure that the inflation projections are adequate. The recently updated Producer Price Index shown below demonstrates the cost growth we are experiencing in energy and supplies, which is trending above the current projections by S&P Global Insights.

**12-Month Percent Change**

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
202												
5	3.8	3.4	3.2	2.4	2.7	2.4	3.2	2.7	3.0	2.8	3.1	3.1

**202**  
**6**      3.1(P)   3.4(P)   4.3(P)   6.0(P)

Source: Producer Price Index, Bureau of Labor Statistics

(P)=Preliminary. All months are subject to change 4 months after original publication

### *(2) Increase Uncompensated Care Funding for Medicaid and Marketplace Changes*

With the recent passage of H.R.1, Medicaid is entering a significantly more complex and restrictive environment that will adversely affect patient coverage. New federal policies will introduce work requirements, expanded exemption verification processes, biannual renewals, and a shortened retroactive coverage period. These changes, combined with reductions in Affordable Care Act subsidy support that are expected to make Marketplace plans unaffordable for millions of individuals, will increase the number of uninsured patients.

Kaiser Family Foundation projects an estimated 210K people in Maryland may lose Medicaid coverage. In the Maryland Medicaid Expansion Group alone, 130K people may lose coverage with Anne Arundel County and Prince George's County projected to experience impacts of 7% and 16%.

ACA Marketplace enhanced premium tax credits ended on January 1, 2026, which increased premiums and reduced or eliminated subsidy levels based on income. This already has impacted participation as the most recent Maryland Health Benefit Exchange data show that enrollment in Maryland Health Connection declined by 33,000 individuals (a 13% decrease) from the start of the plan year through April 2026, compared to a 4% decline in the prior year. Concurrently, approximately 8,000 enrollees shifted from gold plans to bronze plans with deductibles as high as \$10,000, which significantly increases exposure to bad debt and charity care in the hospital setting. These trends represent immediate and measurable impacts on hospital uncompensated care that are occurring now, not in the future. These changes are also expected to increase hospitals' costs to collect. We are projecting another \$1.3m of costs related to Medicaid enrollment efforts starting January 1, 2027.

Given the magnitude and uncertainty of these anticipated changes, it is critical that the HSCRC establish an appropriate funding base in 2026 that reflects the future costs of delivering care and maintaining financial stability across Maryland hospitals. Delaying adjustments until 2028 may limit the state's ability to proactively address rising uncompensated care costs under the current reimbursement framework. Accordingly, Luminis Health supports MHA's recommendation to include an additional 0.20% to support Medicaid enrollment and retention efforts, as well as an additional 0.69% to prospectively account for expected increases in uncompensated care. We also would like the staff to continue to monitor the impact of these changes throughout the year given the substantial changes.

### *(3) Ahead Model Preparation*

We appreciate the 0.5% funding for AHEAD that was included in Hospital Global Budgets. Hospitals will need to operate under dual systems and policies, which will require investment in people(reimbursement specialists, coders, IT professionals, consultants, etc.), significantly change

processes (for example, utilization review and coding workflows) and revise and/or deploy new technology and data infrastructure (for example, building/purchasing new data analytic tools) . We believe the current funding level does not support the investment cost needed for this new model given the significant impact in many areas of the organization. Luminis support's MHA recommendation to include an additional .10% for AHEAD Model Implementation.

### **Provide Adequate Demographic Adjustment based on Population Health Projections**

Global Budgets need to be appropriately adjusted for age-adjusted population. We historically have seen inaccurate funding for age adjusted population growth, which is a critical component of yearly updates when hospitals are under a revenue capped system. There was significant discussion around demographic adjustment and potential changes to better reflect age adjusted population growth and an agreement to revisit the work every two years.

The proposed statewide demographic adjustment for rate year 2027 of only 0.12% does not adequately reflect the expected increase in demand for hospital services based on age adjusted population growth. We continue to believe there needs to be a better prospective adjustment given the aging population growth.

At the least, the national payment adjustor recently incorporated into the demographic adjustment should be spread based on age adjusted population growth rather than the current across the board adjustment to appropriately recognize the growth differences in the State.

With FY27 being part of the AHEAD model base period, not accurately accounting for population growth will create a starting point that will be too low and create long term financial challenges.

### **Health Outcome Payment Effort ("HOPE")**

Luminis Health supports the intent of the HOPE program as articulated in our April 8<sup>th</sup>, 2026 letter. We believe before any dollars are withheld from the update factor to fund the HOPE program more detail is needed regarding how savings will be measured, how clinical interventions will be evaluated and approved, and what guardrails will be applied to protect the integrity of the Program.

Luminis Health appreciates the thoughtful work of the HSCRC staff in developing the draft recommendation for the annual update for rate year 2027 and looks forward to continued collaboration with Commissioners and staff as the final recommendation is considered in June. Given the states favorable Medicare Total Cost of Care (TCOC) savings performance through CY 2025 and recent United States Per Capita Cost (USPCC) trend projections, there is adequate room to increase the demographic and uncompensated care adjustments to account for projected changes in population growth and Medicaid and other coverage losses due to policy changes. We also request additional funding be provided for AHEAD model preparation. These adjustments are critical to support operations and long-term financial stability that will ensure continued access to high quality care for the communities we serve. Please feel free to reach out to us with any questions.

Sincerely,



Kathy Talbot  
Vice President of Revenue Strategy and Optimization

CC:

Dr. Joshua Sharfstein, Chairman  
Dr. James Elliott, Vice Chair  
Jon Blum, Commissioner  
Ricardo Johnson, Commissioner  
Dr. David Maine, Commissioner  
Nicki McCann, Commissioner  
Dr. Farzineh Sabi, Commissioner

May 21, 2026

Dr. Jon Kromm  
Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Executive Director Kromm:

CareFirst Blue Cross Blue Shield appreciates the opportunity to comment on the Draft Annual Update Factor Recommendation for Fiscal Year 2027. We acknowledge that staff and commissioners have the responsibility every year to balance affordability for consumers against economic pressure and uncertainty. Each year, we encourage the Commission to follow its previously agreed upon formulas and policies; in this particular year, we acknowledge and appreciate that Staff adhered to its designed process.

We understand that the additional inflation support of 0.20% is based on the catch-up inflation methodology. As expressed in prior comment letters, we disagree with the chosen base year for this policy. Additionally, in arriving at the 0.20% catch-up inflation, Staff omitted from its calculation the most recently available data. If Staff included FY 2025 data, the conclusion would have been that cumulative underfunding did not surpass the threshold for an adjustment, set at 0.25%. The Commission should recalculate the corridor using the best and most timely data available.

During the May 2026 public meeting, Commission staff shared that Medicare hospital payments per capita in Maryland outpaced the nation in 2025, growing at a rate of 8.4% compared to the national growth rate of 7.5%. Particularly as we enter the AHEAD Model, the Commission should prioritize performance on model savings tests.

We remain concerned about the overall affordability of healthcare for Maryland residents, and the Commission has an important role to play. The decision on the update factor must strike the balance of both keeping pace with inflation to put hospitals in a financial position to deliver services to Marylanders and safeguarding the public from unnecessary costs.

Again, thank you to the Staff for adhering to approved policies and an inclusive stakeholder engagement process. We appreciate the opportunity to comment.

Sincerely,



Arin D. Foreman  
Vice President, Deputy Chief of Staff  
CareFirst BlueCross BlueShield  
1501 S. Clinton Street  
Baltimore, MD 21224

May 22, 2026

Jon Kromm, PhD  
Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

**RE: UMMS Comment Letter on Draft Staff Recommendation for the FY 2027 Update Factor**

Dear Jon:

On behalf of the University of Maryland Medical System (“UMMS”) and its member hospitals, thank you for the opportunity to submit comments in response to the Health Services Cost Review Commission’s (“HSCRC” or “the Commission”) Draft Recommendation for the Update Factor for Rate Year 2027. UMMS understands the core inflation and catchup methodologies that drive the HSCRC’s proposed 3.37% gross inflation allowance and supports the Maryland Hospital Association’s (“MHA”) request for an additional 0.99% to provide prospective consideration for (1) the anticipated impact of House Resolution 1 (“H.R.1”) on hospital uncompensated care costs (“UCC”) and (2) readiness for the Achieving Healthcare Efficiency through Accountable Design (“AHEAD”) Model. UMMS also supports the MHA’s requests to discontinue the productivity adjustment for non-GBR hospitals and to continuously monitor both inflation and uncompensated care in what will surely be a particularly volatile year.

The Maryland Regulatory Model bears the unique burden of ensuring stability for the largest economic driver in Maryland as the healthcare industry navigates the most significant changes to federal funding in recent memory, and it must do so in the context of significant economic volatility due to the national and international landscape. The Comptroller of Maryland’s April 2026 health care industry report effectively summarized the major uncertainties that the healthcare industry faces over the next few years:

- HSCRC will lose rate-setting authority for Medicare beginning in CY2028.
- AHEAD will reduce federal hospital payments by an estimated \$870 million over CY2028-CY2032.
- H.R.1 changes beginning in FY2027 are estimated to trigger coverage loss for 130,000 Marylanders and are estimated to cut Maryland’s federal Medicaid funding by up to \$2.7 billion, representing nearly 20% of Maryland’s current Medicaid budget.
- The cost burden of Medicaid coverage and funding cuts falls hardest on hospitals’ operating budgets.
- Workforce shortages are persistent in the face of increasing demand for services as the population ages.
- Healthcare costs continue to rise, including the costs of workforce, physicians, and drugs/supplies.
- The national and international landscapes drive persistent inflationary and economic uncertainty.

As the Comptroller of Maryland's April 2026 healthcare industry report also points out, the Maryland Model plays a significant role in shaping the economic outlook of the hospital industry, which is a key driver of the healthcare sector and the State more broadly. The healthcare sector is the State's largest source of employment, responsible for 16% of all jobs in Maryland and adding more jobs than any other sector since 2015. In 2025, the healthcare sector employed 427,000 Marylanders, was one of only four sectors that added jobs vs. the prior year, added more jobs than the other three growing sectors combined, and injected \$23 billion in spending to the State economy.

As the Commission grapples with consequential issues surrounding AHEAD, H.R.1, and broader economic uncertainties, the context of our industry's outsized impact on the lives of Marylanders matters. We rely upon the Model to provide revenue stability and protection against volatility to allow us to pursue the value-based goals of reducing cost and improving health outcomes. This sentiment is reflected in our many responses to the HSCRC's call for input on positioning Maryland for success under the AHEAD Model, where we have consistently emphasized that hospitals must come from a position of financial stability to maximally engage in those transformative goals of the Model. UMMS strongly encourages the Commission to focus its efforts to stabilize the Model in three key areas of volatility that pose significant risk to broader Model goals:

- 1. Proactively, and prospectively provide funding to address the impact of H.R.1 on uncompensated care.** Hospitals cannot afford to bear the cost burden of this risk while lagged UCC funding mechanisms take years to catch up, and they should not be asked to do so. UMMS is significantly concerned that the HSCRC's approach of (1) conservatism in FY2027 estimates and (2) monitoring, rather than acting proactively, leaves the hospitals to bear the cost risk of an issue with such a broad range of potential outcomes.
- 2. Monitor FY2027 inflationary pressures throughout the year and act proactively as necessary to address economic and inflationary volatility.** The sheer number and variety of negative cost pressures in the immediate future significantly increases the likelihood that the 3.37% inflation allowance contemplated by the draft recommendation will underfund actual inflation in FY2027. To the extent that this shows in the data throughout the year, the Commission should fund it proactively, as it is not in the State's best interest to carry any known underfunded inflation forward into the future.
- 3. Focus Staff efforts on aligning core methodologies with CMMI and transitioning to AHEAD.** UMMS is increasingly concerned with the amount of methodology work required to build a non-Medicare Regulatory Model, the downside risks of not aligning HSCRC methodologies across payers on core issues such as carveouts, volume, and quality, and the timeline by which all of this needs to be accomplished. We encourage Staff to (1) prioritize alignment with, rather than divergence from, CMMI on core issues such as carveouts, volume, and quality, (2) focus energy on the methodologies that represent the core building blocks for Commercial and Medicaid rate setting, and (3) expend less time and effort on introducing new add-on methodologies such as Length of Stay.

Throughout the progressive iterations of the Total Cost of Care Model since 2014, UMMS has been committed to driving toward the Model's value-based goals. We have been a leader in utilizing facility transformations to redesign care delivery models and expand access to high-value care. We have participated fully in, and made significant investments toward, the HSCRC's Care Redesign Programs with a goal of improving outcomes in the communities we serve. We have committed to being a leader in implementing valid, data-driven efforts to identify health needs and working in partnership within our communities to address them.

To that end, UMMS does not support ending the CTI policy without paying hospitals for their FY 2025 performance. While we have previously gone on record to address the significant issues within the policy, we do not believe those issues should negate any positive rewards which were appropriately earned. We have suggested alternative approaches for dealing with the issues within the CTI policy however, the commission has since voted to cease the program. Because downside protections have diluted HSCRC's ability to pay out rewards for true, transformative savings, the Commission needs to prioritize a potential glidepath for negatively impacted hospitals to keep investment levels steady and reduce risk to critical infrastructure needed for AHEAD performance. We therefore would fully support a set aside in the update factor to fund hospitals and/or systems who have earned rewards within the CTI program.

It is worth restating that the healthcare industry, and the State more broadly, relies on the Maryland Model to provide hospitals stability to continuously and sustainably invest in the value-based goals of the Model. This is true now more than ever, as we find ourselves in incredibly uncertain times. We are unfortunately in the midst of significant disruption and volatility with the loss of Medicare rate-setting authority, the anticipated impact of H.R.1, the abrupt discontinuation of Care Redesign Programs, and broader economic realities. In its annual update factor decision, the Commission has the opportunity to provide stability by addressing multiple drivers of potential volatility. For this reason, UMMS again offers its support of the recommendations outlined in the MHA's comment letter:

- 1. Monitor inflation throughout the rate year**
- 2. Prospectively adjust the uncompensated care (UCC) provision in rates by 0.69%**
- 3. Provide an additional 0.30% to support hospital readiness for H.R.1 and AHEAD**
- 4. Discontinue the productivity adjustment for non-GBR hospitals**

Because we serve so many communities in so many ways, UMMS is deeply invested in the success of the Maryland Model, and we believe strongly that the Commission must act proactively in the face of such uncertainty to provide hospitals with the appropriate resources to ensure access for Maryland and achieve the Model's value-based goals. Now is the time to safeguard the Model against known sources of volatility risk, such as H.R.1, the changes in Medicare regulatory oversight, and ongoing economic uncertainty. I cannot emphasize enough that volatility of this magnitude threatens hospitals' ability achieve the transformation envisioned by the Model. UMMS looks forward to collaborating with our State partners to work toward the broader goal of improving the health of Maryland citizens.

Jon Kromm, PhD

May 22, 2026

Page 4

Sincerely,

A handwritten signature in cursive script that reads "Alicia Cunningham".

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services

University of Maryland Medical System

cc: Joshua Sharfstein, MD Chairman

James Elliott, MD, Vice Chairman

Jonathan Blum, MPP

Ricardo Johnson

David Maine, MD

Nicki McCann, JD

Farzaneh Sabi, MD



maryland  
**health services**  
cost review commission

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Healthcare Outcome Payment Effort  
Final Recommendation  
June 10, 2026

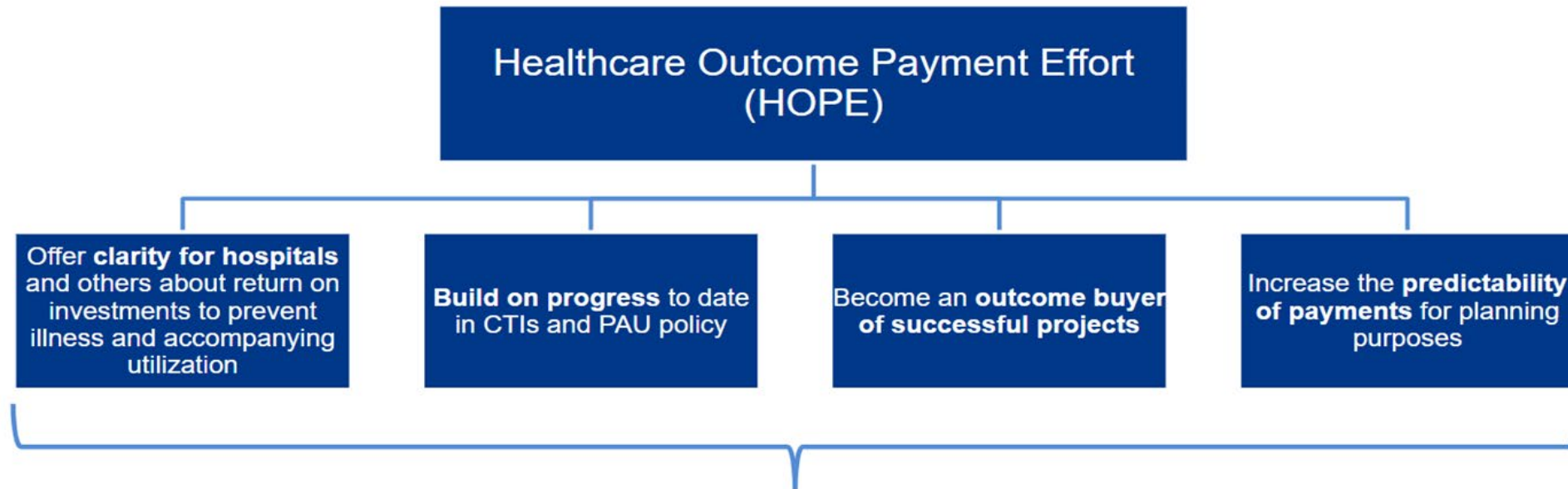
Christa Speicher

## Foundational Context

- AHEAD is designed to reward prevention of illness and accompanying unnecessary hospital utilization.
- Taking advantage of this fundamental incentive is critical for success in meeting the goals of improving health outcomes and reducing costs.
- Feedback from stakeholders on the strengths and weaknesses of existing initiatives has led to the development of a next generation framework.

# HOPE Framework

Care Transformation Initiatives (CTI) have been eliminated for PY4 and PY5. HOPE is the replacement, aligned with AHEAD, which furthers the goals of the Model.



## Achieving Healthcare Efficiency through Accountable Design (AHEAD)

*is designed to reward prevention, reduce unnecessary hospital utilization, and advance coordinated, statewide population health improvement. The model shifts care beyond hospitals toward prevention, primary care, and community-based services that address whole-person needs. Payer alignment under AHEAD reduces fragmentation, promotes value-based care, and supports sustainable cost growth while improving quality and overall population health.*

## AHEAD Goals Emphasized by HOPE

- Shift care upstream to improve outcomes
  - By investing in earlier, more coordinated interventions HOPE can reduce avoidable hospital and emergency department use.
- Strengthen system sustainability and stability
  - By lowering avoidable acute care demand HOPE creates a more predictable operating environment for hospitals and providers.

## Two Paths to Participation

### Care Transformation Framework (CTF)

- *Maryland Acute Hospitals*

### Regional and Statewide Initiatives (RSI)

- *Coordinated by non-hospital organization*
- *Partner with one or more Maryland hospitals*
- *Must have regional scope*

## Key Elements

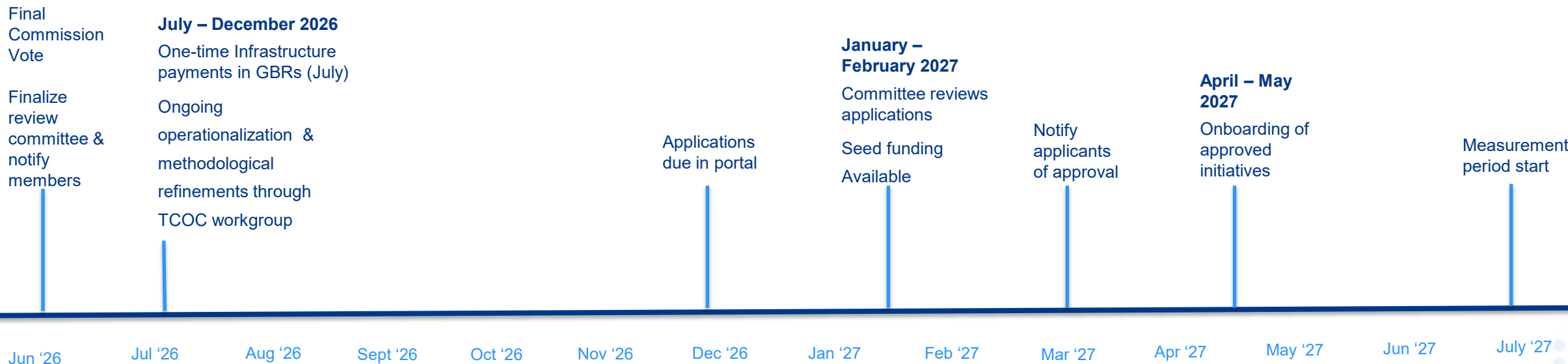
- Voluntary, Upside-Only
- \$50M maximum pay-out for CTF and RSI initiatives require Commission approval
- To qualify for an outcome payment, proposal must include evidence and be reviewed and approved by a 6-person committee (3 state, 3 external)
- One path for hospitals, alone or with partners
- One path for regional or statewide initiatives
- Additional federal funding may be available for successful efforts through special provisions in the AHEAD agreement.

## Changes from Draft Recommendation

- Shift the implementation and measurement start date from FY27 to FY28.
- Provide reasonable flexibility in baseline and measurement periods to account for variation in initiatives and differing stages of program maturity across organizations.
- In FY27, provide one-time infrastructure funding totaling \$25 million, distributed proportionately based on hospitals' Global Budget Revenue (GBR), as well as an additional \$25 million in seed funding for proposals that are qualified under HOPE.
- Allow flexibility regarding eligible applicants for Regional and Statewide Initiatives (RSIs), including permitting hospitals to serve as applicants when appropriate.
- Sunset High-Value Care Plans (HVCPs) at the conclusion of FY26 following completion of final reporting requirements.

# Planning Timeline\*

CTF



RSI



\*Timelines could vary to accommodate specific applicant's specifications

## All-Payer Scope & Medicare Inclusion

- Launch HOPE as an all-payer model by FY2028
- Medicare participation is a priority, but implementation will proceed regardless of CMS timing
- Use case-mix data in FY2028
- Initial focus on inpatient and ED spending
- Engage Medicaid and commercial payers more deeply beginning FY2029
- Supports transition of Medicare global budgets under AHEAD (CY2028)

## Review Process

- **Review Committee made up of industry and state representatives will assess proposals to ensure that they:**
  - **Are grounded in a strong evidence base.**
    - This may be shown by citing peer-reviewed literature, prior evaluations, pilot studies, established practice standards, or technical assistance supporting the proposed intervention.
  - **Address a recognized State health priority.**
    - This may be shown by aligning with the state's AHEAD PHAP or the State Health Improvement Plan (SHIP) or other policies established by the Maryland Department of Health.
  - **Target a clearly defined population.**
    - Specify eligibility criteria and defining characteristics of the target population, such as diagnoses, prior utilization of healthcare services, HCC score, geography, demographics, etc.
  - **Have a high likelihood of producing measurable impact.**
    - This may be shown by a clear and well-justified methodology for estimating the impact of the initiative on health and averted costs.
  - **Avoid adverse impacts on patient experience or total cost of care.**

# Stakeholder Comments and HSCRC Responses

## Implementation Timeline Comments

- Strongly urge delaying HOPE implementation to FY2028 for deliberate development. (MHA)
- Recommends delaying HOPE enrollment to FY2028. (UMMS)
- Recommends eliminating HOPE due to unpredictable CTI-based methodology and the risk to stability during the AHEAD transition.(JHHS)
- Reluctant to support HOPE without a resolution to CTI issues. (Luminis Health)

## Implementation Timeline Response

**HSCRC response:** *Staff appreciate commenters' feedback regarding the proposed implementation timeline and recognize the competing priorities facing hospitals and other stakeholders as the State continues its transition to the AHEAD Model. In response to these concerns, staff recommends delaying HOPE implementation until FY 2028, with an application period beginning in the second half of CY 2026.*

*This revised timeline will provide additional opportunities for stakeholder engagement, program refinement, and operational planning. Staff intend to continue refining HOPE through the TCOC Workgroup during CY 2026 and CY 2027 to ensure that stakeholders have meaningful opportunities to inform implementation and that the model is appropriately aligned with broader care transformation and population health goals.*

# Sustainable Financial Structure and Fund Allocation Comments

- Strong support for HOPE as a stable funding bridge for successful preventive care programs that are often discontinued when pilot funding ends. (Abell Foundation)
- Base funding remains consistent to hospitals. (CalvertHealth)
- Supports predictable, multi-year funding to enable long-term infrastructure investment. (Meritus Health)
- Seeks definitive guidance on near- and long-term funding sources. (MHA)
- Approves of the pre-specified, fixed reward pool but seeks clarity on its impact on annual update factors. (MedStar Health)
- Advocates for reinvesting savings accrued to the state back into the program to accelerate long-term gains. (MedStar Health)
- Recommends incorporating \$50M of infrastructure payments proportional to GBRs in both FY27 and FY28 funding to support current interventions during the transition. (UMMS)
- Supports the \$50M annual funding cap. (JHHS)
- For the FY27 infrastructure funding, funds should be allocated to hospitals that achieved gross shared savings in CTIs and committed to future HOPE participation, rather than allocating by market share. (MedStar Health)

## Sustainable Financial Structure and Fund Allocation Response

*HSCRC response: Staff agree with commenters that funding should be predictable and that sustainable funding is necessary for success. Staff believe that the combination of the commitment to the three-year outcome payout window and assurances regarding the handling of HOPE payments in the savings test address funding sustainability comments.*

*Staff note that HOPE is separate from CTIs and therefore the proposed split between Infrastructure and seed are meant to assist hospitals with continuing care transformation efforts in transition years while beginning to invest in interventions that show promise and will reduce pressure on the system as a whole. Staff recommend that in FY27 HSCRC provides \$25M for infrastructure payments and \$25M for seed funding for approved applicants. For FY28 the measurement period starts, prior to the advent of outcome payments Staff intend to continue funding via additional seed investments or other measures suggested by stakeholders.*

# Measurement, Scope, and Methodology Comments

## Program Scope and Focus

- Urges HSCRC to focus on latent demand, uncompensated care, and physician reimbursement before implementing HOPE. (Adventist HealthCare)
- Strongly opposes narrowing measurement to inpatient/ED costs, arguing for a continued TCOC framework. (UMMS)
- Requests clarity on how the program drives TCOC reductions if limited to inpatient/ED expenditures. (MHA)
- Emphasizes that program methodologies must be transparent (i.e., available funding and distribution) predictable and consistently applied. (CalvertHealth)
- Recommends that review criteria prioritize upstream drivers of health like nutrition and transportation. (Maryland Department of Aging (MDOA))

## Measurement, Scope, and Methodology Response

***HSCRC response:** Staff agree that the policies and methodology behind HOPE should be transparent and consistent and is committed to using the TCOC workgroup for discussions and updates on the HOPE program. Staff recognize there are myriad policy concerns outside of HOPE and believe they can be explored further regardless of HOPE implementation. Staff also understand commenters' concerns about the data limitations and the use of inpatient and emergency department spending in the near term however HSCRC is limited in what data can be utilized but committed to expanding data capabilities in the future. HSCRC will continue to work with CRISP to incorporate more robust data that is available to participants.*

# Measurement, Scope, and Methodology Comments

## Scoring and Payouts

- Supports scoring each intervention based on actual averted hospital costs, rather than on projected savings or a hybrid. (JHHS)
- Supports scoring each intervention at actual averted hospital costs, or 125% of projected averted hospital costs, whichever is lower Option C in Step 2 for scoring because it rewards outperforming projections. (MedStar Health)
- Suggests lowering the proposed minimum saving rate for projections from 50% to 10-20%. (MedStar Health)
- Argues against setting minimum dollar thresholds for savings or performance for project approval, or minimum performance thresholds required to receive a payout. (Primary Care Coalition)

## Measurement, Scope, and Methodology Response

*HSCRC response: Staff agree with commenters that scoring should be tied as closely as possible to demonstrated outcomes and actual performance. Consistent with comments from MedStar Health, staff believe that scoring interventions based on actual averted hospital costs, capped at 125% of projected averted hospital costs, balances rewarding strong performance while maintaining accountability for projections. This approach recognizes interventions that outperform expectations without creating incentives for unrealistic projections.*

*Staff also considered comments regarding the proposed minimum savings threshold. While some commenters recommended reducing or eliminating minimum performance requirements, staff believe that a minimum threshold remains an important safeguard to ensure that scored savings reflect meaningful performance and are not driven by normal variation or small changes in utilization. At the same time, staff recognizes concerns regarding overly stringent requirements and the recommended approach seeks to balance flexibility with accountability*

# Program Design and Operational Clarity Comments

## General Support and Structure

- Believes the HOPE proposal is preliminary and requires more detail on distribution and TCOC impact. (Ascension Saint Agnes, Audacious Capital)
- Commends the voluntary, upside-only structure for lowering barriers to participation. (Meritus Health)
- Supports the foundational design principle that HOPE functions as a voluntary, upside-only program, consistent with the EQIP framework. (JHHS)

## Program Design and Operational Clarity Response

*HSCRC response: Staff appreciate commenters' support for the overall structure of the HOPE model, particularly the voluntary, upside-only design. Staff agree that this approach lowers barriers to participation, encourages innovation, and allows hospitals and other participants to engage in care transformation activities without the financial risks associated with downside accountability. Consistent with comments from Meritus Health and JHHS, staff believe that maintaining HOPE as a voluntary, upside-only model aligns with the principles of EQIP.*

*Staff also agree with commenters that additional operational details regarding payment distribution, intervention qualification, and the model's interaction with total cost of care goals will be important for successful implementation. Throughout model development, staff has sought to balance providing sufficient detail while maintaining flexibility to incorporate stakeholder feedback and lessons learned during implementation and maintain forward momentum. This final recommendation includes additional information regarding funding, payment methodologies, and scoring, and staff will continue to engage stakeholders as operational details are refined.*

# Program Design and Operational Clarity Comments

## Administrative and Data Requirements

- Recommends reducing administrative burden and encouraging multi-payer participation. (Audacious Capital)
- Requests more detail on initiative approval, savings measurement, and impact on annual update factors. (GBMC)
- Urges a "comprehensive crosswalk" showing how HOPE intersects with other existing initiatives (Revenue for Reform, PHAP) to prevent administrative burden and duplication. (MHA)
- Does not support the proposed exclusion of Revenue for Reform initiatives or overlap with primary care investments (Maryland Primary Care Program, Primary Care AHEAD, EQIP Primary Care, Rural health transformation) in potential HOPE applications. (UMMS)
- Supports interoperability (e.g., CRISP and closed-loop referrals) and Shared Savings. (MDOA)

# Program Design and Operational Clarity Response

***HSCRC response:** Staff agree with commenters that coordination with existing initiatives, payer alignment, and operational infrastructure are critical to success. Staff agree that successful implementation of HOPE requires careful integration with existing programs and resources to avoid duplication, maximize impact, and support sustainable care transformation. In response to stakeholder concerns regarding overlap with existing initiatives such as Revenue for Reform, staff included a revised overlaps crosswalk to provide greater clarity regarding how HOPE will interact with other HSCRC programs. While staff agrees that duplicative funding should be avoided, the final recommendation does not categorically exclude participation by organizations involved in other primary care or care transformation initiatives. Rather, the review committee will consider existing resources in a hospital or region and investments available to determine whether additional HOPE funding is appropriate.*

*Staff also agree that broad payer participation is important to maximize the effectiveness and sustainability of care transformation efforts. The Commission will continue to work with CMS to explore opportunities for Medicare participation and alignment, recognizing that multi-payer engagement can strengthen incentives and support greater system-wide impact. Finally, staff agree that leveraging existing data and operational infrastructure will be critical to reducing administrative burden and supporting program evaluation. To that end, staff intend to continue to utilize and build upon existing CRISP capabilities.*

# Recommended Interventions and Focus Areas Comments

## Palliative Care and Serious Illness

- Recommends explicitly identifying palliative care, hospice, and advance care planning as priority HOPE initiatives. (Maryland State Advisory Council on Serious Illness Care)
- Recommends including at least one palliative care expert on the review committee and using patient-reported outcome measures. (University of Maryland School of Medicine)
- Explicitly list palliative care interventions (CAPC- and NHPCO-aligned) as qualifying examples in final guidance. (University of Maryland School of Medicine)

## Community and Prevention

- Focuses on health outcomes and aligns with the AHEAD Model to shift focus toward prevention and community-based services. (Healthcare for All/Maryland Citizens' Health Initiative (MCHI))
- Emphasizes increasing physician awareness and community-based partnerships. (MedChi)
- Recommends adding diagnostic excellence within the scope of HOPE supported interventions. HSCRC should add “presenting symptoms” to the list of illustrative target population characteristics in the review criteria. (Johns Hopkins - Tele-Dizzy)

## Recommended Interventions and Focus Areas Response

***HSCRC response:** Staff appreciate commenters' recommendations regarding palliative care, prevention, community-based services, diagnostic excellence, and intervention evaluation. Staff agree that these areas represent important opportunities to improve outcomes and reduce avoidable utilization. The final recommendation is intended to provide flexibility for a broad range of evidence-based interventions, including those focused on serious illness care and community-based prevention. Staff will consider stakeholder feedback as implementation details are developed and believe many of these recommendations may be appropriately addressed through program guidance and the review process. Additionally, the review committee will consider intervention design, target populations, available community resources, and subject matter expertise when evaluating proposed projects.*

# Regional and Statewide Initiatives (RSI) Comments

## RSI Caps and Structure

- Recommends capping the RSI track at 20–25% of total HOPE funding. (JHHS)
- Views regional initiatives as less accountable and not necessarily patient-facing. (JHHS)
- RSI payments should remain uncapped. (Primary Care Coalition)
- Concerned with lack of cap for RSI and generally with financing leaving the hospital; notes risk of misalignment with Geo AHEAD. (UMMS)
- RSI framework is needed to sustain and scale high-acuity, low-volume services/settings. (The Day Clinic)

## Partner Inclusion and Engagement

- Opposes excluding hospitals from being anchor entities in regional collaboratives. (MedStar Health)
- Requests formal recognition of Area Agencies on Aging (AAAs) as RSI anchor entities. (MDOA)
- Requires Local Health Department (LHD) Engagement in Regional & Statewide Initiatives. (MACHO)
- Strengthen and Specify “Community Partner” Language to explicitly include Local Health Departments. (MACHO)
- Requires Regional Governance Structures with Public Health Participation (RSI). (MACHO)

## Regional and Statewide Initiatives (RSI) Response

*HSCRC response: Staff appreciates the range of feedback on the proposed Regional and Statewide Initiatives (RSI) track, including comments on funding structure, accountability, governance, and eligible entities. With respect to funding levels and caps, staff notes that the Commission will vote on the RSI initiatives on an individual basis and can provide feedback on the appropriate scale and structure of funding, as part of the voting process. Staff also agree with commenters emphasizing the importance of accountability and meaningful patient-facing impact for RSI projects. While RSI is intended to support regional coordination and system-level interventions, all projects will be subject to review to ensure appropriate accountability and alignment with program objectives.*

*Regarding participation and governance, staff support a flexible but structured approach. Hospitals may serve as applicants or anchor entities where appropriate; however, this will be contingent on review committee determination that the proposed structure is justified and that required community partnerships are in place. RSI projects will be expected to demonstrate meaningful engagement with relevant community partners and cannot be hospital-led in isolation. Staff also agree that participation of public health entities and community organizations, including Local Health Departments and other stakeholders such as Area Agencies on Aging where appropriate, is an important component of effective regional collaboration and will be considered within the review process.*

# Overview of HOPE Final Recommendation

- HOPE creates a clear, accountable, and financially predictable framework to advance Maryland's participation in AHEAD.
- Through two participation pathways, the Care Transformation Framework and Regional & Statewide Initiatives, the model supports both hospital-led and cross-sector transformation efforts while maintaining standards for savings validation and performance measurement.
- Its voluntary, upside-only structure, capped and stable funding approach, and commitment to earned payouts are designed to reduce financial risk and encourage sustained investment in prevention and utilization reduction.
- By prioritizing all-payer alignment, transparent, data-driven measurement, and thoughtful coordination with existing programs, HOPE positions the State to transition toward a model in which it acts as an outcome purchaser rewarding interventions that demonstrably improve health outcomes, advance equity, control costs, and strengthen system sustainability.



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cost review commission

# Healthcare Outcome Payment Effort (HOPE)

## Final Recommendation

June 10, 2026

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## Final Recommendation

This final recommendation outlines the policy framework for the Healthcare Outcomes Payment Effort (HOPE) beginning in Fiscal Year 2027 (FY27). HOPE replaces Care Transformation Initiatives (CTIs) which Health Services Cost Review Commission (HSCRC) is sunsetting on June 30, 2026. The objective of HOPE is to create a clear, predictable, and accountable payment structure that enables hospitals and community partners to invest in interventions that improve care and health and enhance the financial sustainability of the health care system. HOPE seeks to sustain and expand population health investments that advance Achieving Healthcare Efficiency through Accountable Design's (AHEAD) goals and drive meaningful system transformation.<sup>1</sup>

## Differences from Draft Recommendation

Over the past two months, stakeholders provided extensive comments and feedback that informed the policy refinements and timeline modifications reflected in the draft recommendation. Staff carefully reviewed stakeholder input alongside lessons learned from prior and existing care transformation programs and, based on this analysis, recommend the following key updates to the original HOPE draft recommendation:

1. Shift the implementation and measurement start date from FY27 to FY28.
2. Provide reasonable flexibility in baseline and measurement periods to account for variation in initiatives and differing stages of program maturity across organizations.
3. In FY27, provide one-time infrastructure funding totaling \$25 million, distributed proportionately based on hospitals' Global Budget Revenue (GBR), as well as an additional \$25 million in seed funding for proposals that are qualified under HOPE.
4. Allow flexibility regarding eligible applicants for Regional and Statewide Initiatives (RSIs), including permitting hospitals to serve as applicants when appropriate.
5. Sunset High-Value Care Plans (HVCPs) at the conclusion of FY26 following completion of final reporting requirements.

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<sup>1</sup> <https://www.cms.gov/priorities/innovation/innovation-models/ahead>

## Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The objective of HOPE is to create a clear, predictable, and accountable payment structure that enables hospitals, payers, and community partners to invest in interventions and share in savings. HOPE seeks to sustain and expand population health investments that advance AHEAD's goals and drive meaningful system transformation.	HOPE is a voluntary, upside-only outcome payment model that rewards hospitals and non-hospital partners for measurable reductions in inpatient and ER spending while improving population health. It creates predictable, performance-based funding pathways and positions the State as an outcome purchaser of successful projects.	Hospitals benefit from financial predictability, reduced risk, and incentives to invest in prevention and population health initiatives. The program encourages collaboration and supports infrastructure and transformation efforts.	Payers and consumers gain from improved care and health outcomes and greater financial sustainability of the health care system. The model promotes preventive care and community-based interventions that enhance patient experience and reduce unnecessary utilization.	HOPE prioritizes interventions that target defined populations and address upstream health drivers to improve outcomes and reduce disparities.

## Hope Alignment with AHEAD

This proposal is designed to align closely with the AHEAD Population Health Accountability Plan (PHAP) and the broader vision advanced by stakeholders.<sup>2</sup> By reinforcing shared accountability for measurable improvements in population health, the framework supports the State's commitment to responsible cost growth, improved outcomes, and transparent performance expectations across the delivery system.

It also reflects a deliberate opportunity for prevention and restorative health that emphasizes upstream interventions, chronic disease management, and community-based supports. In addition, the framework

<sup>2</sup> <https://health.maryland.gov/mche/pages/default.aspx>

seeks to encourage cross-sector collaboration and broader care delivery models. This approach recognizes that meaningful population health gains can benefit from engagement from community providers, social service organizations, and public health partners. Payer alignment under AHEAD reduces fragmentation, promotes value-based care, and supports sustainable cost growth while improving quality and overall population health.

## Introduction to the HOPE Policy

The State's participation in AHEAD presents a pivotal opportunity to strengthen the alignment between payment policy and population health improvement. Building on stakeholder feedback regarding the strengths and limitations of prior initiatives including Potentially Avoidable Utilization (PAU) and CTIs, HOPE builds upon progress to date on these policies by offering clearer guidance to hospitals and partners regarding the return on investment. Described in further detail in sections below, it is a voluntary, upside only model that increases payment predictability and supports planning and investment using an annual payout structure of an initial 3 years based on validated savings. At the same time, it represents a model in which the State becomes an outcome purchaser rewarding measurable, successful interventions.

## Paths to Participation

Participation can occur through one of two primary pathways: the Care Transformation Framework (CTF) or Regional & Statewide Initiatives (RSI). Both pathways aim to improve population health while reducing emergency room and inpatient expenditures and share savings with participants. They differ in who leads the effort, how approval is obtained, and the scale of intervention.

### Path 2: Care Transformation Framework (CTF)

Under the CTF pathway, participation begins at the individual hospital level. A single hospital—or a group of hospitals—applies directly to implement a hospital-defined intervention. Although multiple hospitals may participate in the same intervention, the focus remains hospital specific. The hospital identifies the target population and designs interventions aimed at reducing emergency room and inpatient costs in the state of Maryland (not limited to their own emergency room and inpatient costs). Applications are reviewed by a committee for program qualification, and Commission votes for each intervention are not required. If approved, participating hospitals share in the savings generated. Outcome payments based on savings are calculated over a measurement window and paid for three years, at which time a review will be completed and consideration given for extension. The model is intended to be all-payer, with the goal of working with CMMI to include Medicare.

## Path 2: Regional & Statewide Initiatives (RSI)

The RSI pathway operates at a broader geographic scale. Interventions focus on defined regional populations and aim to reduce emergency room and inpatient expenditures across a broader geography. Participation is through a regional or statewide entity and must include at least one hospital partner. The entity may be technology or digital health companies, health plans, community-based organizations, etc. The entity is preferred as the applicant, rather than a hospital, and all partners involved must have a formal Memorandum of Understanding (MOU) or contractual agreement in place outlining collaboration and funds distribution. Unlike the CTF pathway, RSI proposals require both review committee qualification and a Commission vote for approval. Like CTF, participants are eligible for outcome payments over a certain measurement period. Outcome payments based on savings will be made for three years, at which time a review will be completed, and consideration will be given for extension. The model is intended to be all-payer, with the goal of working with CMMI to include Medicare.

## Funding and Payment Structure

Based on continued stakeholder feedback, the funding and payment structure was intentionally designed to provide clarity, predictability, and reduced financial risk. Stakeholders emphasized the importance of ensuring that participation would not affect the hospital update factor. In response, the model is not funded through the update factor, separating it from base rate updates. To further promote certainty, outcome payments will be initially anticipated to be \$50 million each year, with the commission only able to qualify interventions with up to \$100 million in possible outcome payments, recognizing that initiatives may not be successful in reducing costs. Payments will be made regardless of position on the Medicare savings test or other affordability tests. Outcome payments for Regional and Statewide initiatives are individually approved by the Commission and will not count towards the \$50 million.

As the policy developed through the workgroup process, stakeholders expressed strong support for a model that encourages participation without exposing providers to financial risk like the CTI offset. As a result, the program is voluntary and structured as an upside-only outcome payment model, with no downside risk. The approach laid out below lowers barriers to entry and enables hospitals and initiative partners to focus on transformation efforts without the concerns of an offset or penalty. HOPE rewards sustained performance rather than short-term fluctuations. Outcome payments are therefore based on average savings achieved over a performance window. Hospitals and Statewide and Regional Initiative partners receive 50% of measured savings, ensuring aligned incentives across participating entities.

The Care Transformation Framework is designed to advance the HSCRC's central objective: balancing three critical priorities—promoting continued investment in care transformation, ensuring payment predictability for hospitals, and maintaining affordable, long-term cost growth. For the Care Transformation

Framework, the Commission proposes to establish a fixed statewide funding of \$50 million per year for FY27, FY28, and FY29. At the same time, approved initiatives collectively may not materially exceed projected annual savings of \$100 million. Each initiative seeking participation must submit projected total savings, which will be independently validated by Commission staff and reviewed by the committee to ensure methodological rigor. Interventions will be scored at actual averted hospital costs, or 125% of projected averted hospital costs, whichever is lower. If the score is less than half of the projected averted hospital costs, there will be no scored savings, i.e. minimum saving rate for projections is 50%. Payments will equal 50% of scored savings. Once established, payouts for individual initiatives will remain fixed for the subsequent three years (with continuation of the initiatives). Additionally, the statewide funding level may be increased in future years if the program demonstrates sufficient success.

Recognizing that FY27 represents a transition year and all-payer program measurement is not available, HSCRC would like to maintain support for care transformation infrastructure by providing a one-time \$25M payment distributed proportionally based on Global Budget Revenues (GBRs) to sustain transformation infrastructure across all hospitals in Maryland (if systems wish to designate this funding within their system, other than the GBR, they will be given that option). In addition, HSCRC will provide \$25M in seed funding for HOPE applicants whose proposals are approved by the review committee and whose applications justify the need for seed funding. Seed funding may be allocated to non-hospital initiatives. In FY28 the measurement period starts and potentially new seed funding may be provided to approved applicants.

## Savings Measurement

Stakeholders called for a measurement methodology that is rigorous, transparent, and data driven. Payment levels will be based on statistically reliable, validated savings performance, calculated using all-payer claims data to ensure consistency and broad accountability. Statistical methodologies will incorporate risk adjustment to account for differences in patient complexity and case mix across participants. Expected spending will be adjusted using established clinical risk indicators (e.g., APR-DRG risk scores) derived from claims data to ensure that performance comparisons reflect true efficiency gains rather than underlying population differences. As outlined above, HSCRC will afford organizations and initiatives flexibility in their baseline for measuring performance. Staff will collaborate with industry and measurement experts to develop and document a transparent, statistically defensible approach. While staff will continue to prioritize reliable measurement, they may allow payouts based on varying years of certified savings performance.

## All-Payer Scope

The overarching goal is for HOPE to operate effectively in an all-payer environment by FY2028. HSCRC agrees that including Medicare in the future strengthens the model and will work with CMS to pursue participation. At the same time, HSCRC is committed to moving forward with implementation even if

Medicare participation is not finalized, ensuring progress toward an all-payer structure regardless of federal timing.

A central component of this effort is ensuring access to comprehensive claims data. For FY2028, the intent is to use case-mix data to operationalize HOPE for non-Medicare payers if necessary. Initially, data and measurement will focus on inpatient and emergency department spending, providing a clear and manageable starting point. Over time, the model is expected to expand in scope as data capabilities and payer alignment evolve. HSCRC is interested in partnering with commercial payers and Medicaid, with a goal of deeper engagement beginning in FY2029 and in subsequent program years. The program's design and operational infrastructure are being developed to accommodate hospitals, Medicare, Medicaid, and commercial payers in a coordinated manner. This approach is intended to minimize administrative complexity, reduce conflicting financial incentives across payers, and maintain feasibility as Medicare global budgets transition under AHEAD in CY2028.

## **Review Committee and Qualifying Initiative Criteria**

The review committee will be established to ensure that proposed interventions are rigorously evaluated, practically grounded, and aligned with program goals before moving forward. The goal of the committee is that it brings informed perspectives to the assessment and qualification of initiatives. The committee not only evaluates proposals against established standards but also will help the HSCRC to communicate guidance to applicants, helping to strengthen submissions and encourage high-quality, well-designed interventions over time.

Importantly, the committee is designed to leverage practical expertise. Including members with experience in care transformation ensures that recommendations are not merely theoretical, but actionable and implementable in real-world settings. This blend of public accountability and operational insight helps promote initiatives that are feasible, impactful, and positioned to deliver meaningful results.

### **Review Committee**

Initiative proposals will be evaluated by a formal review committee, with the HSCRC Director making the final determination based on the committee's recommendation. The body serves as a review panel rather than a public decision-making entity.

The panel will consist of six members, evenly divided between governmental and non-governmental representatives. Governmental members will include one HSCRC staff member (serving as co-chair), one representative from MDH, and one representative from either MHCC or CHRC. The three non-governmental members will be experts in health care transformation or community health, with one serving as co-chair. Conflict-of-interest standards will apply. Panel experts may not be involved in any pending

applications and must recuse themselves where appropriate. The panel will also establish and apply the process by which recommendations are made.

## Review Criteria

In assessing applications, the committee will ensure that submissions reflect meaningful and well-designed interventions. They will ensure that qualified initiatives are a balance of opportunities across the state given the specific challenges of each region and consider the resources already dedicated when considering how to prioritize funding. Specifically, proposals should demonstrate that they:

- Are grounded in a strong evidence base. This may be shown by citing peer-reviewed literature, prior evaluations, pilot studies, established practice standards, or technical assistance supporting the proposed intervention.
- Address a recognized State health priority. This may be shown by aligning with the state's AHEAD PHAP or the State Health Improvement Plan (SHIP) or other policies established by the Maryland Department of Health.
- Target a clearly defined population, by specifying eligibility criteria and defining characteristics of the target population, such as diagnoses, prior utilization of healthcare services, HCC score, geography, demographics, etc.
- Have a high likelihood of producing measurable impact related to the intervention. This may be shown by a clear and well-justified methodology for estimating the impact of the initiative on health and averted costs.
- Avoid adverse impacts on patient experience or total cost of care.

## Program Overlaps and Transitions

The following reflects areas where this program overlaps with other existing HSCRC initiatives and policies. These intersections are important to acknowledge, as participation rules, funding, and operational requirements may interact in nuanced ways. Staff will provide more detailed guidance, as necessary, on any specific parameters of these overlaps in subsequent communications to ensure clarity and alignment.

- **New Paradigms in Care Delivery (NPCD)**
  - Funding can be used for up-front investments to support qualified programs under HOPE
- **Revenue for Reform (RfR)**
  - Generally, Revenue for Reform initiatives should not also receive funding under HOPE to avoid duplicative funding.
- **Episode Care Improvement Program (ECIP)**
  - Ends December 31, 2026, with no savings offset for 7/1/26–12/31/26.

- **Episode Quality Improvement Program (EQIP)**
  - Participation in both programs is allowed.
- **Efficiency Policy**
  - Payments should not count against hospitals under the efficiency policy.
- **Maryland Primary Care Program (MDPCP)**
  - Participation in both programs is allowed.
  - The review committee will need to consider that resources are already dedicated to primary care to prioritize other strategies.

## High-Value Care Plans (HVCP)

High-Value Care Plans were established as part of the FY25 Update Factor to support the development and reporting of new and existing strategies aimed at reducing potentially avoidable utilization in priority areas identified through the VBCI tool or other approved tools. Hospitals were subject to a clawback of funds if reporting requirements were not met.

As HSCRC transitions to the next generation of care transformation through HOPE, Staff recommend sunseting HVCPs at the conclusion of FY26, following completion of final reporting. Beginning in FY27, hospitals will retain this revenue within their GBR as long as they designate a senior executive responsible for the hospital's population health efforts.

## Discussions of Comments Received

### HOPE Comment Letters Summary

The Commission received 22 comment letters from a diverse group of organizations in response to the Healthcare Outcome Payment Effort (HOPE) proposal. Overall, commenters were generally supportive of the goals and direction of HOPE, while identifying areas where additional clarification, refinement, or operational flexibility may strengthen implementation. Themes raised across comments included implementation timing, funding and financial structure, scoring methodology, review committee composition, interaction with CTIs, funding caps, all-payer participation, and administrative considerations.

### Implementation Timeline

Several organizations expressed concerns regarding the proposed implementation timeline. The Maryland Hospital Association (MHA) strongly urged delaying HOPE implementation until FY 2028 to allow for more deliberate development and stakeholder engagement. Similarly, the University of Maryland Medical System (UMMS) recommended delaying enrollment until FY 2028. Johns Hopkins Health System (JHHS) recommended eliminating HOPE altogether, citing concerns regarding the unpredictability of the CTI-based

methodology and potential risks to stability during the transition to the AHEAD Model. Luminis Health indicated reluctance to support HOPE without first resolving existing CTI-related issues.

*HSCRC response: Staff appreciate commenters' feedback regarding the proposed implementation timeline and recognize the competing priorities facing hospitals and other stakeholders as the State continues its transition to the AHEAD Model. In response to these concerns, staff recommends delaying HOPE implementation until FY 2028, with an application period beginning in the second half of CY 2026. This revised timeline will provide additional opportunities for stakeholder engagement, program refinement, and operational planning. Staff intend to continue refining HOPE through the TCOC Workgroup during CY 2026 and CY 2027 to ensure that stakeholders have meaningful opportunities to inform implementation and that the model is appropriately aligned with broader care transformation and population health goals.*

## **Sustainable Financial Structure and Fund Allocation**

Many commenters supported the concept of HOPE as a stable funding mechanism for successful preventive care programs that often lose support when funding expires. The Abell Foundation strongly supported HOPE as a bridge to sustain effective interventions over time. CalvertHealth emphasized that base funding remains consistent for hospitals under the proposal, while Meritus Health highlighted the importance of predictable, multi-year funding to support long-term infrastructure investments. Several organizations requested additional clarity regarding funding sources and mechanics. MHA sought definitive guidance on both near- and long-term funding sources. MedStar Health supported the use of a pre-specified, fixed reward pool but requested clarification regarding any potential impact on annual update factors. MedStar also advocated reinvesting state savings generated through the program back into HOPE to accelerate future gains. Commenters also addressed the proposed funding cap and allocation methodology. JHHS supported the proposed \$50 million annual funding cap. MedStar Health recommended that FY 2027 infrastructure funding be allocated to hospitals that generated gross shared savings through CTIs and demonstrated a commitment to future HOPE participation, rather than distributing funds based on market share. UMMS recommended incorporating \$50 million in infrastructure payments proportional to the GBRs in both FY 2027 and FY 2028 to sustain existing interventions during the transition period.

*HSCRC response: Staff agree with commenters that funding should be predictable and that sustainable funding is necessary for success. Staff believe that the combination of the commitment to the three-year outcome payout window and assurances regarding the handling of HOPE payments in the savings test address funding sustainability comments.*

*Staff note that HOPE is separate from CTIs and therefore the proposed split between Infrastructure and seed are meant to assist hospitals with continuing care transformation efforts in transition years while beginning to invest in interventions that show promise and will reduce pressure on the system as a whole. Staff recommend that in FY27 HSCRC provides \$25M for infrastructure payments and \$25M for seed funding for approved applicants. For FY28 the measurement period starts, prior to the advent of outcome payments Staff intend to continue funding via additional seed investments or other measures suggested by stakeholders.*

## **Measurement, Scope, and Methodology**

### **Program Scope and Focus**

Several comments focused on the scope and intended focus of HOPE. Adventist HealthCare urged the HSCRC to prioritize addressing latent demand, uncompensated care, and physician reimbursement before implementing HOPE. UMMS strongly opposed narrowing program measurement to inpatient and emergency department expenditures, arguing that the Total Cost of Care (TCOC) framework should remain central. Similarly, MHA requested clarification regarding how the program would drive reductions in total cost of care if measurements are limited to inpatient and emergency department spending. CalvertHealth emphasized that program methodologies, including funding availability and distribution approaches, should be transparent, predictable, and consistently applied. The Maryland Department of Aging (MDOA) recommended prioritizing Upstream Drivers of Health, such as nutrition and transportation supports, within project review criteria.

*HSCRC response: Staff agree that the policies and methodology behind HOPE should be transparent and consistent and is committed to using the TCOC workgroup for discussions and updates on the HOPE program. Staff recognize there are myriad policy concerns outside of HOPE and believe they can explore further regardless of HOPE implementation. Staff also understand commenters' concerns about the data limitations and the use of inpatient and emergency department spending in the near term however HSCRC is limited in what data can be utilized but committed to expanding data capabilities in the future. HSCRC will continue to work with CRISP to incorporate more robust data that is available to participants.*

### **Scoring and Payouts**

A number of commenters focused on the proposed scoring methodology. JHHS supported scoring interventions based on actual averted hospital costs rather than projected savings or hybrid approaches. MedStar Health supported scoring interventions at either actual averted hospital costs or 125% of projected averted hospital costs, whichever is lower, consistent with HSCRC's proposed framework. MedStar noted

that this approach appropriately rewards interventions that outperform projections. MedStar also recommended reducing the proposed minimum savings rate for projected savings from 50% to between 10 and 20%. The Primary Care Coalition opposed the use of minimum dollar thresholds for savings or performance when approving projects and similarly opposed requiring minimum performance thresholds for organizations to receive payouts.

*HSCRC response: Staff agree with commenters that scoring should be tied as closely as possible to demonstrated outcomes and actual performance. Consistent with comments from MedStar Health, staff believe that scoring interventions based on actual averted hospital costs, capped at 125% of projected averted hospital costs, balances rewarding strong performance while maintaining accountability for projections. This approach recognizes interventions that outperform expectations without creating incentives for unrealistic projections.*

*Staff also considered comments regarding the proposed minimum savings threshold. While some commenters recommended reducing or eliminating minimum performance requirements, staff believe that a minimum threshold remains an important safeguard to ensure that scored savings reflect meaningful performance and are not driven by normal variation or small changes in utilization. At the same time, staff recognizes concerns regarding overly stringent requirements and the recommended approach seeks to balance flexibility with accountability*

## **Program Design and Operational Clarity**

### **General Support and Structure**

Several commenters expressed general support for the structure of the program while requesting additional detail. Ascension Saint Agnes and Audacious Capital noted that the proposal remains preliminary and would benefit from additional information regarding payment distribution and total cost of care impacts. Greater Baltimore Medical Center (GBMC) requested additional detail regarding initiative approval processes, savings measurement methodologies, and any impact on the annual update factor. Meritus Health commended the voluntary, upside-only structure, citing its ability to lower barriers to participation. JHHS similarly supported the foundational design principle that HOPE operates as a voluntary, upside-only model, consistent with the structure of EQIP.

*HSCRC response: Staff appreciate commenters' support for the overall structure of the HOPE model, particularly the voluntary, upside-only design. Staff agree that this approach lowers barriers to participation, encourages innovation, and allows hospitals and other participants to engage in care transformation activities without the financial risks associated with downside accountability. Consistent with comments from*

*Meritus Health and JHHS, staff believe that maintaining HOPE as a voluntary, upside-only model aligns with the principles of EQIP.*

*Staff also agree with commenters that additional operational details regarding payment distribution, intervention qualification, and the model's interaction with total cost of care goals will be important for successful implementation. Throughout model development, staff has sought to balance providing sufficient detail while maintaining flexibility to incorporate stakeholder feedback and lessons learned during implementation and maintain forward momentum. This final recommendation includes additional information regarding funding, payment methodologies, and scoring, and staff will continue to engage stakeholders as operational details are refined.*

### **Administrative and Data Requirements**

Commenters also highlighted operational and administrative considerations. Audacious Capital recommended reducing administrative burden and encouraging broader multi-payer participation. MHA requested development of a comprehensive crosswalk demonstrating how HOPE would interact with existing programs such as Revenue for Reform and the Population Health Advancement Program (PHAP) to avoid duplication and administrative complexity. UMMS opposed the proposed exclusion of Revenue for Reform initiatives and overlap with other primary care investments, including the Maryland Primary Care Program, Primary Care AHEAD, EQIP Primary Care, and Rural Health Transformation initiatives. MDOA expressed support for interoperability efforts, including CRISP integration, closed-loop referrals, and shared savings approaches.

*HSCRC response: Staff agree with commenters that coordination with existing initiatives, payer alignment, and operational infrastructure are critical to success. Staff agree that successful implementation of HOPE requires careful integration with existing programs and resources to avoid duplication, maximize impact, and support sustainable care transformation. In response to stakeholder concerns regarding overlap with existing initiatives such as Revenue for Reform, staff included a revised overlaps crosswalk to provide greater clarity regarding how HOPE will interact with other HSCRC programs. While staff agrees that duplicative funding should be avoided, the final recommendation does not categorically exclude participation by organizations involved in other primary care or care transformation initiatives. Rather, the review committee will consider existing resources in a hospital or region and investments available to determine whether additional HOPE funding is appropriate.*

*Staff also agree that broad payer participation is important to maximize the effectiveness and sustainability of care transformation efforts. The Commission will continue to work with CMS to explore opportunities for Medicare participation and alignment, recognizing that multi-payer engagement can strengthen incentives*

*and support greater system-wide impact. Finally, staff agree that leveraging existing data and operational infrastructure will be critical to reducing administrative burden and supporting program evaluation. To that end, staff intend to continue to utilize and build upon existing CRISP capabilities.*

## **Recommended Interventions and Focus Areas**

Several organizations recommended expanding the focus on palliative care and serious illness interventions. The Maryland State Advisory Council on Serious Illness Care recommended explicitly identifying palliative care, hospice services, and advance care planning as priority HOPE initiatives. The University of Maryland School of Medicine recommended including at least one palliative care expert on the review committee and incorporating patient-reported outcome measures into program evaluation. The School of Medicine also recommended explicitly listing CAPC- and NHPCO-aligned palliative care interventions as qualifying examples in final program guidance.

Commenters broadly supported the emphasis on prevention and community-based interventions. Healthcare for All and the Maryland Citizens' Health Initiative Coalition (MCHI) highlighted HOPE's alignment with the AHEAD Model and its focus on shifting care toward prevention and community-based services. MedChi emphasized the importance of increasing physician awareness and strengthening community-based partnerships. Johns Hopkins Tele-Dizzy recommended including diagnostic excellence within the scope of HOPE-supported interventions. The organization also suggested adding "presenting symptoms" to the illustrative list of target population characteristics used in project review criteria.

*HSCRC response: Staff appreciate commenters' recommendations regarding palliative care, prevention, community-based services, diagnostic excellence, and intervention evaluation. Staff agree that these areas represent important opportunities to improve outcomes and reduce avoidable utilization. The final recommendation is intended to provide flexibility for a broad range of evidence-based interventions, including those focused on serious illness care and community-based prevention. Staff will consider stakeholder feedback as implementation details are developed and believe many of these recommendations may be appropriately addressed through program guidance and the review process. Additionally, the review committee will consider intervention design, target populations, available community resources, and subject matter expertise when evaluating proposed projects.*

## **Regional and Statewide Initiatives (RSI)**

Several comments addressed the proposed Regional and Statewide Initiatives (RSI) track. JHHS recommended limiting RSI funding to between 20 and 25% of total HOPE funding, expressing concerns that regional initiatives may be less accountable and less directly patient facing. In contrast, the Primary Care Coalition argued that RSI payments should remain uncapped. UMMS expressed concern regarding the absence of an RSI funding cap and broader concerns about funding leaving the hospital. UMMS also noted potential misalignment with the Geo AHEAD Model. The Day Clinic indicated that the RSI framework is necessary to sustain and scale high-acuity, low-volume services and care settings.

Several commenters recommended expanding participation requirements and governance structures for RSI projects. MedStar Health opposed excluding hospitals from serving as anchor entities within regional collaboratives. MDOA requested formal recognition of Area Agencies on Aging (AAAs) as eligible RSI anchor entities. The Maryland Association of County Health Officers (MACHO) recommended requiring Local Health Department participation in Regional and Statewide Initiatives, strengthening the definition of community partners to explicitly include Local Health Departments, and establishing regional governance structures that incorporate public health representation.

*HSCRC response: Staff appreciates the range of feedback on the proposed Regional and Statewide Initiatives (RSI) track, including comments on funding structure, accountability, governance, and eligible entities. With respect to funding levels and caps, staff notes that the Commission will vote on the RSI initiatives on an individual basis and can provide feedback on the appropriate scale and structure of funding, as part of the voting process. Staff also agree with commenters emphasizing the importance of accountability and meaningful patient-facing impact for RSI projects. While RSI is intended to support regional coordination and system-level interventions, all projects will be subject to review to ensure appropriate accountability and alignment with program objectives.*

*Regarding participation and governance, staff support a flexible but structured approach. Hospitals may serve as applicants or anchor entities where appropriate; however, this will be contingent on review committee determination that the proposed structure is justified and that required community partnerships are in place. RSI projects will be expected to demonstrate meaningful engagement with relevant community partners and cannot be hospital-led in isolation. Staff also agree that participation of public health entities and community organizations, including Local Health Departments and other stakeholders such as Area Agencies on Aging where appropriate, is an important component of effective regional collaboration and will be considered within the review process.*

## Conclusion

HOPE creates a clear, accountable, and financially predictable framework to advance Maryland's participation in AHEAD. Through two participation pathways, the Care Transformation Framework and Regional & Statewide Initiatives, the model supports both hospital-led and cross-sector transformation efforts while maintaining standards for savings validation and performance measurement. Its voluntary, upside-only structure, capped and stable funding approach, and commitment to earned payouts are designed to reduce financial risk and encourage sustained investment in prevention and utilization reduction. By prioritizing all-payer alignment, transparent, data-driven measurement, and thoughtful coordination with existing programs, HOPE positions the State to transition toward a model in which it acts as an outcome purchaser rewarding interventions that demonstrably improve health outcomes, advance equity, control costs, and strengthen system sustainability.



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# CRISP Funding Request – FY 2027

Final Recommendation

## Staff Recommendation

- Staff is recommending the Commission approve a total of \$10.9 million in funding through hospital rates in FY 2027 to support the HIE and continue the investments to advance the Maryland Model through both direct funding and obtaining federal MES matching funds.



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**Maryland's Statewide Health  
Information Exchange,  
the Chesapeake Regional Information  
System for our Patients: FY 2027  
Funding**

**Final Recommendation**

June 10, 2026

This is a final recommendation for consideration by the Commission.

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## List of Abbreviations

AHEAD	Achieving Healthcare Efficiency through Accountable Design Model
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
CRS	CRISP Reporting Services
EQIP	Episode Quality Improvement Program
FY	Fiscal year
FFY	Federal fiscal year
HIE	Health information exchange
HITECH	Health Information Technology for Economic and Clinical Health Act
HSCRC	Health Services Cost Review Commission
IAPD	Implementation Advanced Planning Document
MDH	Maryland Department of Health
MHCC	Maryland Health Care Commission
MHIP	Maryland Health Insurance Plan
MES	Medicaid Enterprise System
TCOC	Total Cost of Care

## Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
To fund and sustain a robust Health Information Exchange, CRISP, for activities related to the HSCRC and the Maryland Model.	Include an assessment in hospital rates to generate funding to support CRISP projects and operations to further the goals of the Maryland Model	Hospitals benefit from CRISP programs and pay a separate user fee. This assessment is a pass through and has no impact on hospitals.	CRISP provides vital coordination and reporting that allow hospitals and other Maryland providers to enhance the quality and cost effectiveness of the care provided.	Provider reporting supported by CRISP will collect data on social determinants of health and disparities in health outcomes in order to further the goals of improved health equity under the Model.

## Summary of the Recommendation

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the Maryland Model and the public interest,<sup>1</sup> this recommendation identifies the following amounts of State-supported funding for fiscal year (FY) 2027 to the Chesapeake Regional Information System for our Patients (CRISP):

- Direct funding and matching funds under Medicaid Enterprise System (MES) Federal Programs for Health Information Exchange (HIE) operations and infrastructure (\$3,504,000)
- Direct funding and Medicaid Enterprise System (MES) matching funds for reporting and program administration related to population health, the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, and hospital regulatory initiatives (\$7,396,000).

Therefore, Staff recommends that the HSCRC provide funding to CRISP totaling \$10,900,000 for FY 2027. As a result, the HSCRC will be funding approximately 19 percent of CRISP's Maryland funding, compared to the budgeted 26 percent in FY 2026. In FY 2026, HSCRC's share of funding for CRISP increased to address anticipated reductions in Federal matching grants. However, no changes to Federal funding occurred and prior years' match rates are anticipated to continue in federal fiscal year (FFY) 2027. HSCRC is decreasing the FY 2027 assessment given the sustained level of federal match funding.

Staff solicited public comment on the draft recommendation through May 20, 2026, but did not receive any comment letters.

<sup>1</sup> MD. CODE ANN., Health-Gen §19-219(c).

## Background – Past Funding

Over the past fifteen years, the Commission has approved funding to support the general operations of the CRISP HIE and reporting services through hospital rates as shown in Table 1.

*Table 1. HSCRC Funding for CRISP HIE and Reporting Services, Last 15 Years*

<b>CRISP Budget: HSCRC Funds Received</b>	
FY 2013	\$1,313,755
FY 2014	\$1,166,278
FY 2015	\$1,650,000
FY 2016	\$3,250,000
FY 2017	\$2,360,000
FY 2018	\$2,360,000
FY 2019	\$2,500,000
FY 2020	\$5,390,000
FY 2021	\$5,170,000
FY 2022	\$9,240,000
FY 2023	\$4,800,000
FY 2024	\$4,800,000
FY 2025	\$8,420,000
FY 2026	\$12,060,000
FY 2027	\$10,900,000

## Funding Through Hospital Rates

Beginning in FY 2020, HSCRC assumed full responsibility for managing the CRISP assessment, previously shared with the Maryland Health Care Commission (MHCC). CRISP-related hospital rate assessments are paid into an HSCRC fund, and the HSCRC reviews the invoices for approval of appropriate payments to CRISP. This process – which includes bi-weekly update meetings, monthly written reports, and auditing of the expenditures – has created transparency and accountability. CRISP’s reimbursement from the HSCRC is provided in two tranches: one relating to state match funding of core HIE operational costs and the other related to Reporting and Program Administration. In addition, the Reporting and Program Administration payments are split into fixed recurring costs and a periodic true up. This funding approach allows CRISP to recover operational reimbursement from the HSCRC in a timelier fashion.

## Funding Through Federal Matching

HSCRC funding has been used to obtain federal matching funds throughout the history of the program. The federal match is obtained through the program outlined below.

## Medicaid Enterprise System (MES) Matching Funds

MES is a federal program designed to promote effective care for Medicaid beneficiaries through investments in information technology infrastructure. Medicaid benefits from CRISP's data sharing and reporting initiatives through the care management and cost control initiatives facilitated for all Medicaid patients under CRISP all-payer activities and for dual-eligible patients under CRISP's Medicare activities.

Activities funded under this element of the assessment include point-of-care and other provider data sharing initiatives, and CRISP reporting tools utilizing the Medicare claims and the HSCRC's hospital case mix data. Hospitals, the HSCRC, and other stakeholders use CRISP reporting from these datasets to manage and track progress under several HSCRC programs and enable hospitals to identify and pursue care efficiency initiatives.

Under MES, state funds are eligible for either a 90 percent match for new reporting initiatives or a 75 percent match for ongoing reporting. The assessment funding will provide the State's portion of this match as well as the State's Fair Share amount. The Fair Share represents the amount that benefits Medicaid before considering the federal and state match. Starting in FY 2024 the methodology for calculating the State's Fair Share amount was changed resulting in a greater portion being borne by the State.

## Other Funding

CRISP's Maryland activities are also financed through user fees paid by hospitals and payers as well as funding received from MDH (See Table 2). Payer user fees have historically been a small share of total CRISP revenue. User fees represent approximately 11 percent of total funding for FY 2027.

## Description of Activities Funded

Activities funded directly by this assessment and from earned federal matching fall into the two categories described below. The descriptions below outline, in general terms, the programs for which funds will be used. Staff will direct funding to specific programs within the general parameters described.

### Category 1: HIE Operations Funding and Infrastructure

The value of an HIE rests in the premise that more efficient and effective access to health information will improve care delivery while reducing administrative health care costs. The General Assembly charged the MHCC and HSCRC with the designation of a statewide HIE.<sup>2</sup> In the summer of 2009, MHCC conducted a competitive selection process which resulted in awarding state designation to CRISP, and HSCRC approved up to \$10 million in startup funding over a four-year period through Maryland's unique all-payer

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<sup>2</sup> MD. CODE ANN., Health-Gen §19-143(a).

hospital rate setting system. CRISP maintained designation through multiple renewal processes, with the most recent occurring in 2022 HSCRC's annual funding for CRISP is illustrated in Table 1 above.

The use of HIEs is a key component of health care transformation, enabling clinical data sharing among appropriately authorized and authenticated users. The ability to exchange health information electronically in a standardized format is critical to improving health care quality and safety.

Many states, along with federal policy makers, look to Maryland as a leader in HIE implementation. CRISP continues to build the infrastructure necessary to support existing and future use cases and to assist HSCRC in administering per-capita and population-based payment structures under the Maryland Model. A return on the State's investment is demonstrated through implementation of a robust technical platform that supports innovative use cases to improve care delivery, increase efficiencies in health care, and reduce health care costs. MDH made extensive use of CRISP's capabilities during the COVID crisis.

The total amount of funding recommended by Staff for FY 2027 for the HIE function is \$3,504,000.

## **Category 2: Reporting and Program Administration Related to Population Health, the AHEAD Model, and Hospital Regulatory Initiatives**

These initiatives were designed to reduce health care expenditures and improve outcomes for all Marylanders. Many of these programs focus on unmanaged high-needs Medicare patients and patients dually eligible for Medicaid and Medicare, consistent with the goals of the AHEAD Model. These initiatives encourage collaboration between and among providers, provide a platform for provider and patient engagement, and allows for confidential sharing of information among providers. To succeed under the AHEAD Model, providers will need a variety of tools to manage high-needs and complex patients that CRISP is currently working to develop and deploy.

Based on broad program participation, including non-hospital providers, and the ability to secure federal match funds, these programs will be funded through a combination of assessments and federal matching funds. This recommendation covers three components:

- (1) Funding for population health and cost and quality management reporting in support of HSCRC regulations and the AHEAD Model;
- (2) Funding for program administration related to programs under the AHEAD Model; and
- (3) Funding for innovative reporting initiatives such as enhanced data on social determinants of health and the integration of electronic health record data into statewide hospital quality measurement

The total amount recommended by Staff for FY 2027 for the activities described above is \$7,396,000.

## Staff Recommendation

Staff is recommending the Commission approve a total of \$10.9 million in funding through hospital rates in FY 2027 to support the HIE and continue the investments to advance the Maryland Model through both direct funding and obtaining federal MES matching funds.

Table 2 shows the funding through hospital rates and the federal match that will be generated from the MES funding as well as the user fee and MDH funding.

*Table 2. FY 2027 Recommended Rate Support for CRISP as a share of estimated total Maryland Funding*

Project Name	Hospital Rates	Budgeted Federal Funding	User Fees	Maryland Department of Health	Maryland Total
HIE Operations	\$3,504,000	\$10,387,000	\$6,123,000	\$3,165,000	\$23,179,000
Reporting and Program Administration	\$7,396,000	\$10,511,000	\$0	\$3,095,000	\$21,002,000
Other non-HSCRC programs	\$0	\$11,493,000	\$0	\$2,309,000	\$13,802,000
<b>Total Funding</b>	<b>\$10,900,000</b>	<b>\$32,391,000</b>	<b>\$6,123,000</b>	<b>\$8,569,000</b>	<b>\$57,983,000</b>
<b>% Of Total</b>	<b>19%</b>	<b>56%</b>	<b>11%</b>	<b>15%</b>	<b>100%</b>

# Final Recommendation: Inpatient Length of Stay Policy

# Final Recommendations

1. Implement a monitoring program for all-payer inpatient length of stay (IP LOS) for acute-care hospitals.
2. Assess the risk-adjusted, mean IP LOS for acute admissions, with clinical exclusions and winsorization to minimize the effect of extreme outlier cases.
3. Provide summary level reports and patient level files that allow hospitals to track IP LOS and stratify by patient characteristics (i.e., primary diagnosis, patient disposition) or other factors to identify areas of opportunity.
4. Publicly report hospital IP LOS performance at HSCRC Commission meetings.
5. Propose inclusion of IP LOS for payment in RY2029 or RY2030 as part of the portfolio of hospital quality and population health incentives for Maryland Global Budgets (i.e., non-Medicare hospital global budgets).
6. Monitor to ensure the policy achieves its intended result (lower IP LOS and ED LOS) without unintended effects on readmission rates and ED revisits.

# Introduction

- Global budgets and TCOC accountability incentivize hospitals to reduce preventable hospital admissions and lower inpatient length of stay (IP LOS)
- While the Maryland Model has been successful in reducing hospital admissions, it has been less effective in reducing IP LOS
- Many hospitals in Maryland have an average IP LOS higher than National
- Although admission volumes have declined, the concurrent increase in IP LOS has resulted in a net rise in inpatient resource utilization as measured by total bed days
- Unconstrained increases in IP LOS may undermine the financial sustainability of global budgets
- Maryland's emergency departments are currently among the most crowded in the nation, and managing IP LOS is a critical for improving ED wait times.

## Updates to Draft Recommendation

- Initial implementation is focused on monitoring, followed by recommendation for payment incentives in RY2029 or RY2030
- Situate IP LOS incentives within an existing quality policies to enhance cohesiveness and maintain current level of revenue at risk
- Address concern over outliers by capping IP LOS values at 30 days
- Exclude APR-DRG/payer groups that have norms based on <2 cases



# Stakeholder Feedback

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## Summary of Comment Letters

- Received from MHA, UMMS, JHHS, Adventist, MedStar, Luminis, Frederick Health, Lifebridge Health, and Health Means Everything.
- Stakeholders voiced conceptual concerns, as well as concerns related to implementation details.
- Conceptual concerns:
  - Lack of alignment with AHEAD model/federal priorities
  - Existing model incentives and programs already address IP LOS
  - Measure results show MD already performs well
  - Rising mean IP LOS is result of moving lower-acuity patients to OP settings

## Comment Letters: Implementation Concerns

- Inadequate risk adjustment
- Request to focus policy exclusively on patients discharged to home
- Request for "Monitoring-Only" status or delay in implementation
- Concerns about premature discharge/patient safety
- Need to exclude outlier cases (behavioral health, complex social needs)

## Staff Response: IP LOS Policy Not Aligned with AHEAD

- The rapid increase in IP LOS, if continued, is likely to threaten model financial viability and worsen ED crowding and patient outcomes.
- While alignment with AHEAD policies is an important priority, staff believes action is needed to ensure financial viability and address ED LOS.
- Incentives in the surge policy could similarly worsen IP LOS, so it is appropriate for the Commission to enact counterbalancing measures.
- The model does incentivize managing IP LOS. However, it appears existing incentives have not been clear enough to prevent IP LOS growth for most hospitals and below-average performance for some.

## Stakeholder Concern: Worsening IP LOS Due to Rising Acuity

- The TCOC Model encouraged hospitals to treat lower-acuity patients in outpatient settings
- Because of this shift, the patients remaining in inpatient care are sicker and thus require longer LOS

## Staff Response: Worsening IP LOS Due to Rising Acuity

- Staff investigated this issue in several ways
  - Evaluating change in IP LOS over time with risk adjustment to account for patient acuity
  - Evaluating mean IP LOS changes for patients undergoing major surgery that has never been the target of diversion to OP settings
  - Evaluating change in total bed days as well as mean LOS
  - Evaluating correlation between volume shift to OP and growth of IP LOS
- None of these analyses support the stakeholder contention that increasing IP LOS is the result of model dynamics outside of hospital control

# IP LOS Rise Not Caused by Moving Lower-Acuity Patients to OP

## Baseline Scenario

Patient	Unit	LOS
1	CCU	6
2	Med/Surg	2

Bed Days: 8  
Patients: 2  
Mean LOS: 4

## Reduced Acuity Scenario

Patient	Unit	LOS
1	CCU	6
2	Med/Surg	2

Bed Days: 6  
Patients: 1  
Mean LOS: 6

## Increased Bed Days + Lower Acuity Scenario

Patient	Unit	LOS
1	CCU	8
3	Med/Surg	2

Bed Days: 8  
Patients: 1  
Mean LOS: 8

## Stakeholder Feedback: Risk Adjustment Issues

- HCUP national norms do not reflect Maryland's higher acuity case mix.
- Model ignores Academic Center specialization and lacks necessary peer grouping.
- Policy fails to adjust for discharge disposition or post-acute care shortages.
- External delays like payer prior authorizations or administrative denials are not addressed.
- Need to exclude or adjust for complex outlier cases like behavioral health boarding.

## Staff Response: Risk Adjustment Issues

- Staff has updated the policy to address outliers (guardianship, payer delays, behavioral placement) by winsorizing at 30 days of IP LOS
- The risk adjustment methodology reflects a similar approach used in Commission-approved quality policies.
- APR-DRG/SOI/payer adjustment account for differences in acuity.
  - SOI was specifically designed to address utilization outcomes like LOS
  - The HCUP survey includes AMCs as well as behavioral and complex cases, so these are risk-adjusted appropriately
- Adjusting by Medicaid status within payer category accounts for social factors
- Maryland AMC's have higher mean LOS than AMC's elsewhere after risk-adjusting
- As in other policies, assessing Improvement effectively controls for hospital-specific factors (AMC, low SES, etc) not addressed by risk adjustment

# Staff Response: Additional Implementation Concerns

- Request for "Monitoring-Only" status or delay in implementation
  - Staff agree and have updated the policy to monitoring-only for RY 2028 and will propose financial penalties and rewards starting in RY 2029 or RY 2030.
  - Future payment policy should:
    - Include IP LOS as part of portfolio of hospital quality and population health incentives non-Medicare hospital global budgets.
    - Maintain current revenue at risk for hospital quality and population health (i.e., part of the 6 percent at-risk) and be included under the maximum revenue guardrail policy.
- Concerns about premature discharge/patient safety
  - Staff agrees that managing IP LOS could result in premature discharge. Existing quality programs (RRIP, QBR) are likely to detect unanticipated consequences of the IP LOS policy. Future policy should set revenue at risk for IP LOS lower than that for readmissions specifically to avoid this issue.

## Hospital Concerns: Post-Acute Care Barriers

- Post-acute care capacity constraints and barriers are often outside of hospital control
- Systemic drivers include behavioral health boarding, guardianship delays, and pediatric overstays
- Care transition delays directly impact IP LOS
- Hospitals identify lack of coordination between payers, post-acute providers, and state agencies as a major hurdle
- Need for policy alignment with ongoing work from the MHCC Post-Acute Care Workgroup and ED WTR Commission

# Staff Response: Post-Acute Care Barriers

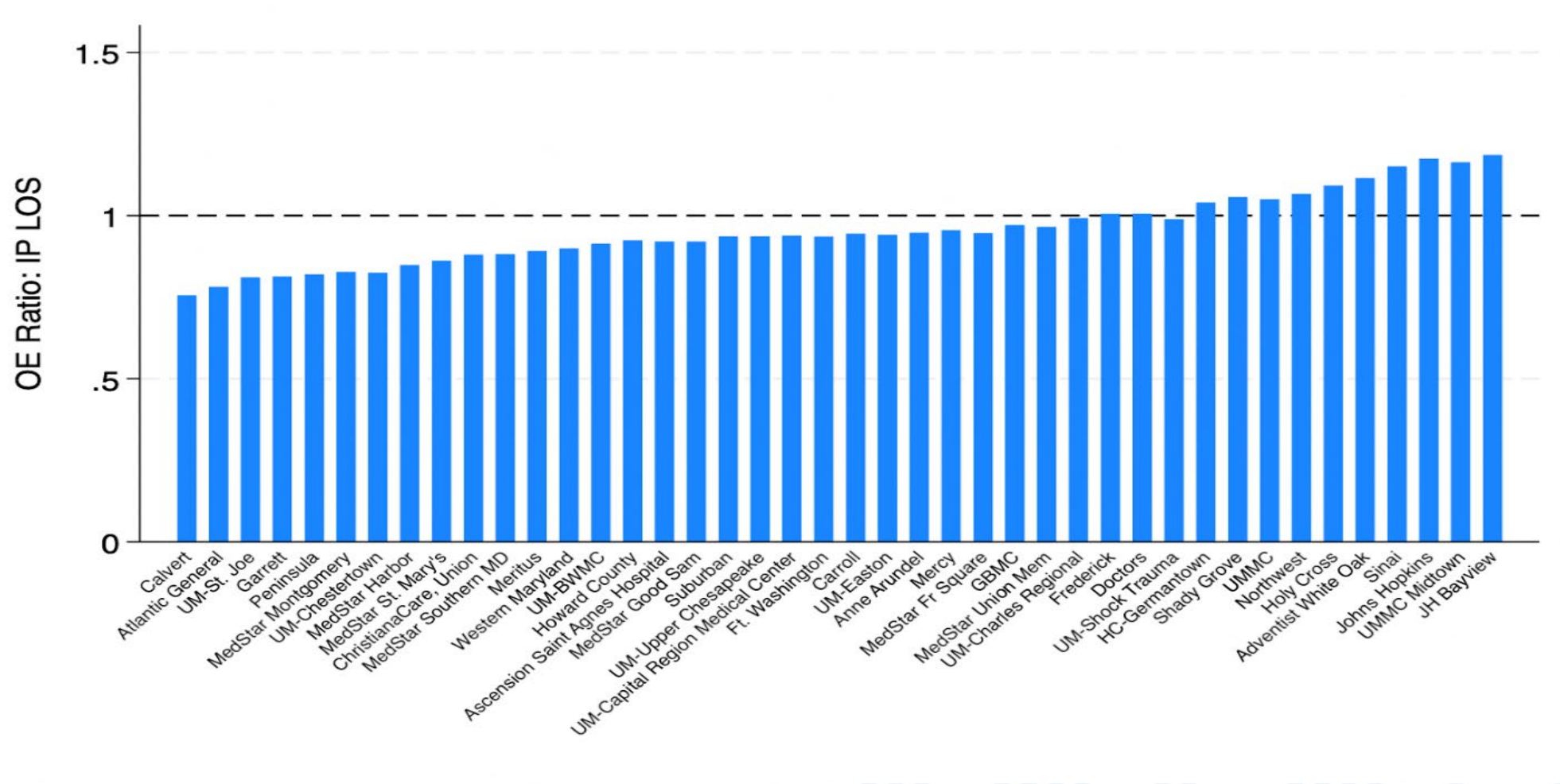
- Statewide, patients discharged to post-acute care have an IP LOS above the national average.
- However, Staff analysis suggests excluding patients discharged to SNF is unnecessary and has negative policy implications
  - Hospital IP LOS performance is inversely correlated with the volume of post-acute discharges — Hospitals with more SNF discharges have lower IP LOS
  - Hospitals with long LOS for SNF patients also have long LOS for those discharged home, indicating elevated IP LOS is a hospital issue, rather than one due mostly to external factors
  - Management of patients requiring SNF care represents an opportunity for hospitals to improve quality of care and IP LOS
  - Improvement component of policy effectively adjusts for hospital and regional factors (such as SNF availability) that influence IP LOS
- IP LOS reporting will include stratification by discharge destination. Staff will monitor and propose policy changes as necessary

# Final Recommendations

1. Implement a monitoring program for all-payer inpatient length of stay (IP LOS) for acute-care hospitals.
2. Assess the risk-adjusted, mean IP LOS for acute admissions, with clinical exclusions and winsorization to minimize the effect of extreme outlier cases.
3. Provide summary level reports and patient level files that allow hospitals to track IP LOS and stratify by patient characteristics (i.e., primary diagnosis, patient disposition) or other factors to identify areas of opportunity.
4. Publicly report hospital IP LOS performance at HSCRC Commission meetings.
5. Propose inclusion of IP LOS for payment in RY2029 or RY2030 as part of the portfolio of hospital quality and population health incentives for Maryland Global Budgets (i.e., non-Medicare hospital global budgets).
6. Monitor to ensure the policy achieves its intended result (lower IP LOS and ED LOS) without unintended effects on readmission rates and ED revisits.

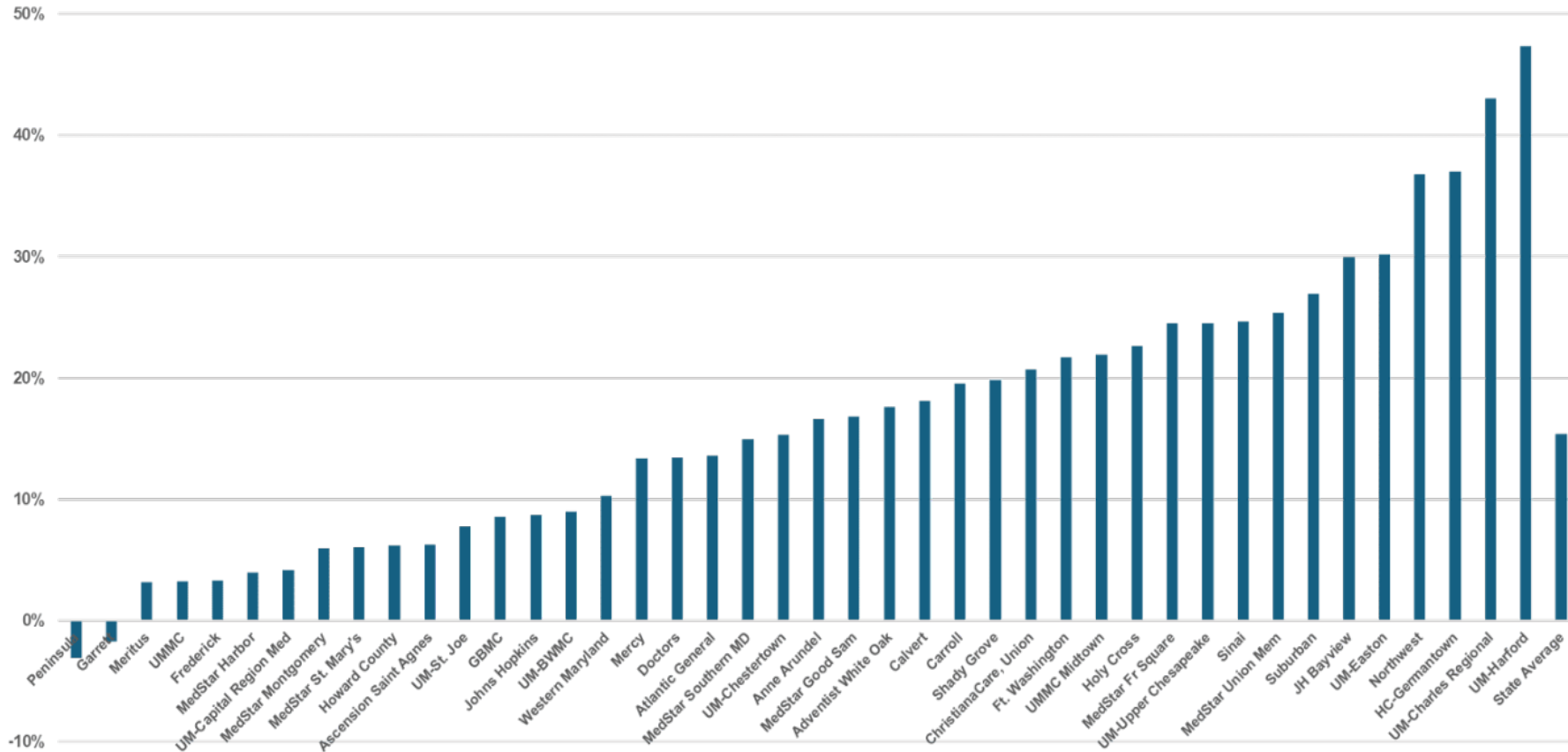
# Appendix: Additional Analytics

# 25% of MD Hospitals Have Risk-Adjusted IP LOS Higher Than National Average



Source: HSCRC FY2025 Casemix, risk adjusted for APR-DRG, and payer using 2023 HCUP norms

# Between 2018 and 2024, IP LOS Increased at Most Hospitals

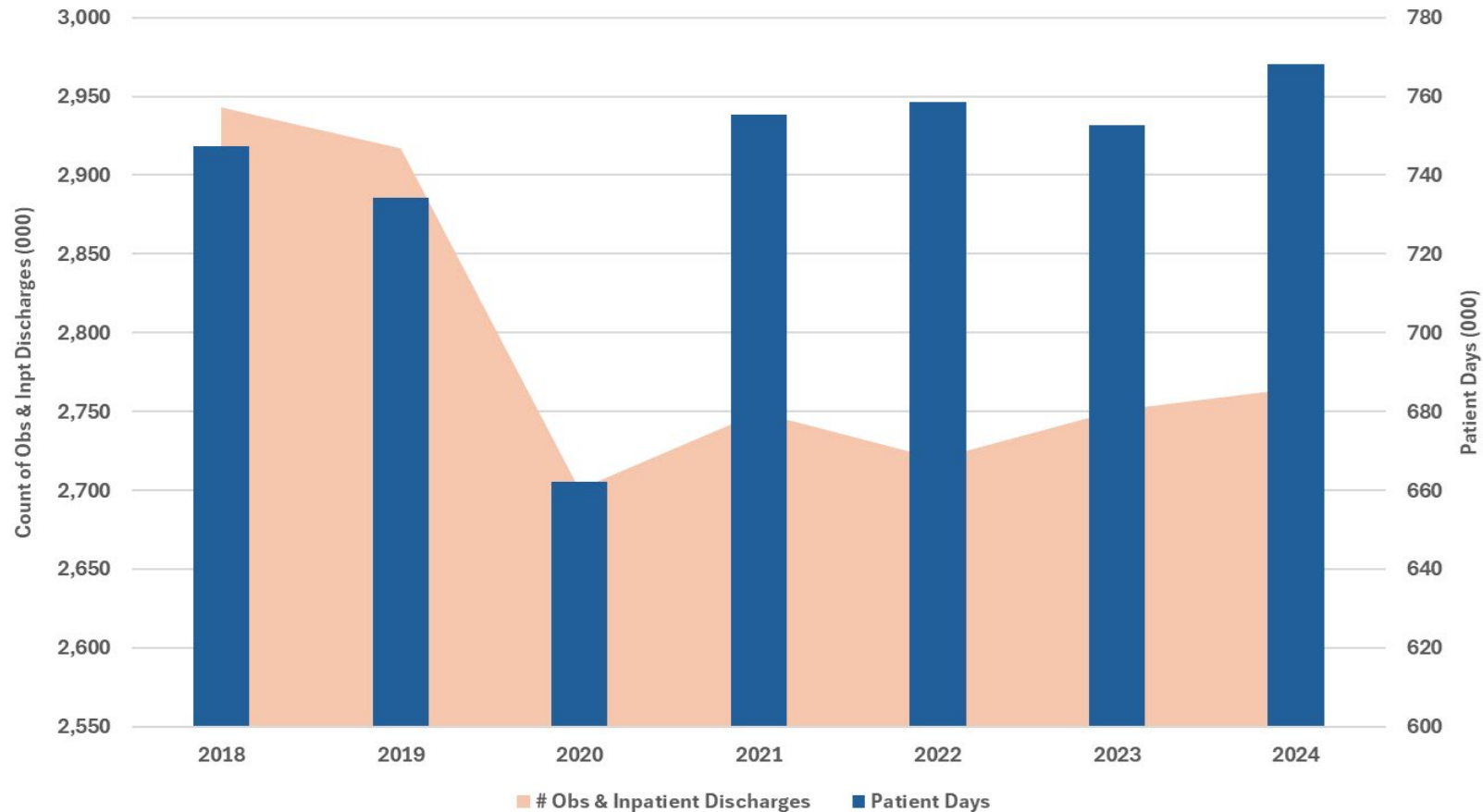


15 Hospitals had IP LOS increase of more than 20 percent between 2018 and 2024

Only two of the State's hospitals experienced decreases during the period

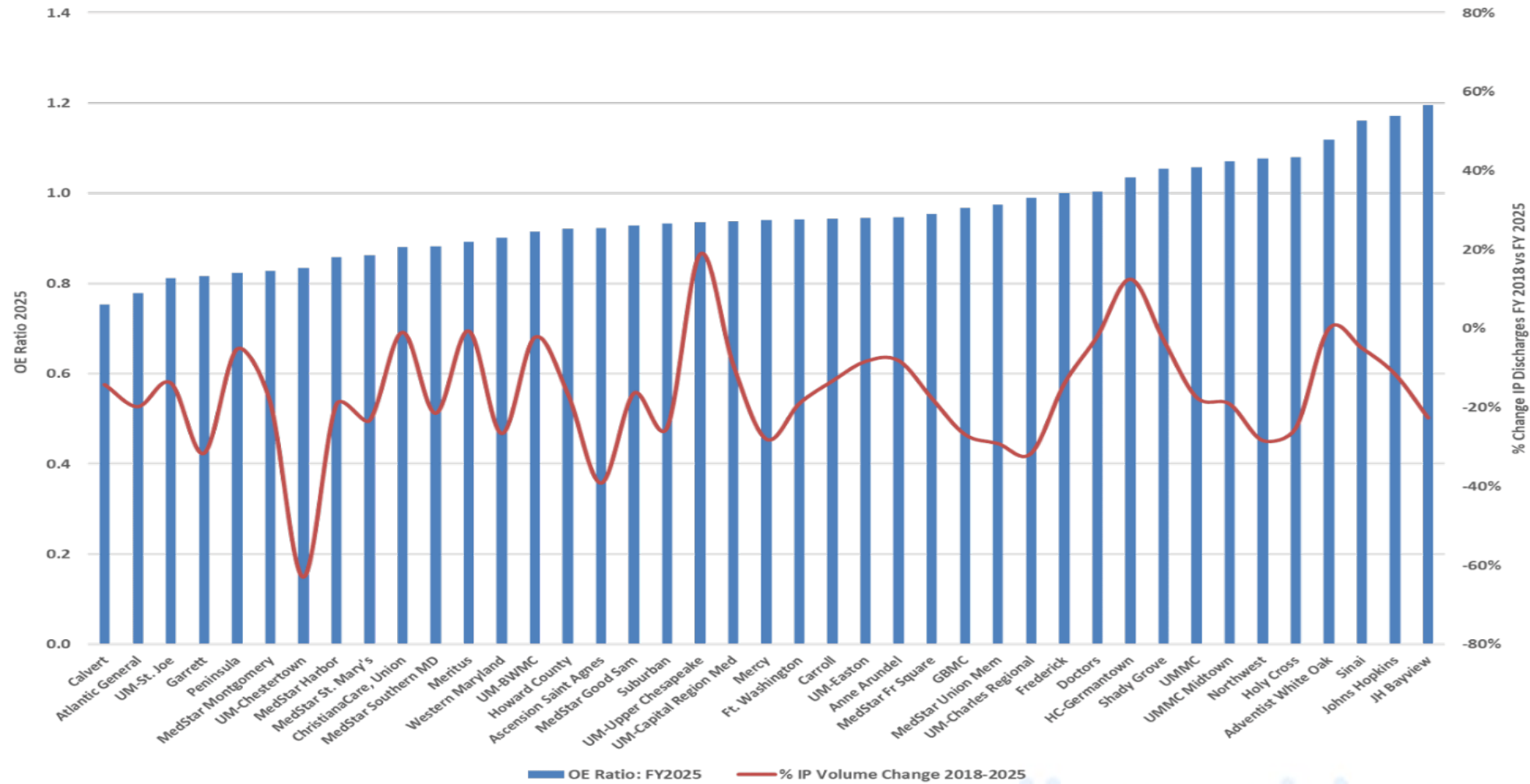
Source: HSCRC FY2018 & FY 2024 Casemix.

# There Was a Net Gain in Statewide Bed Days Over Time



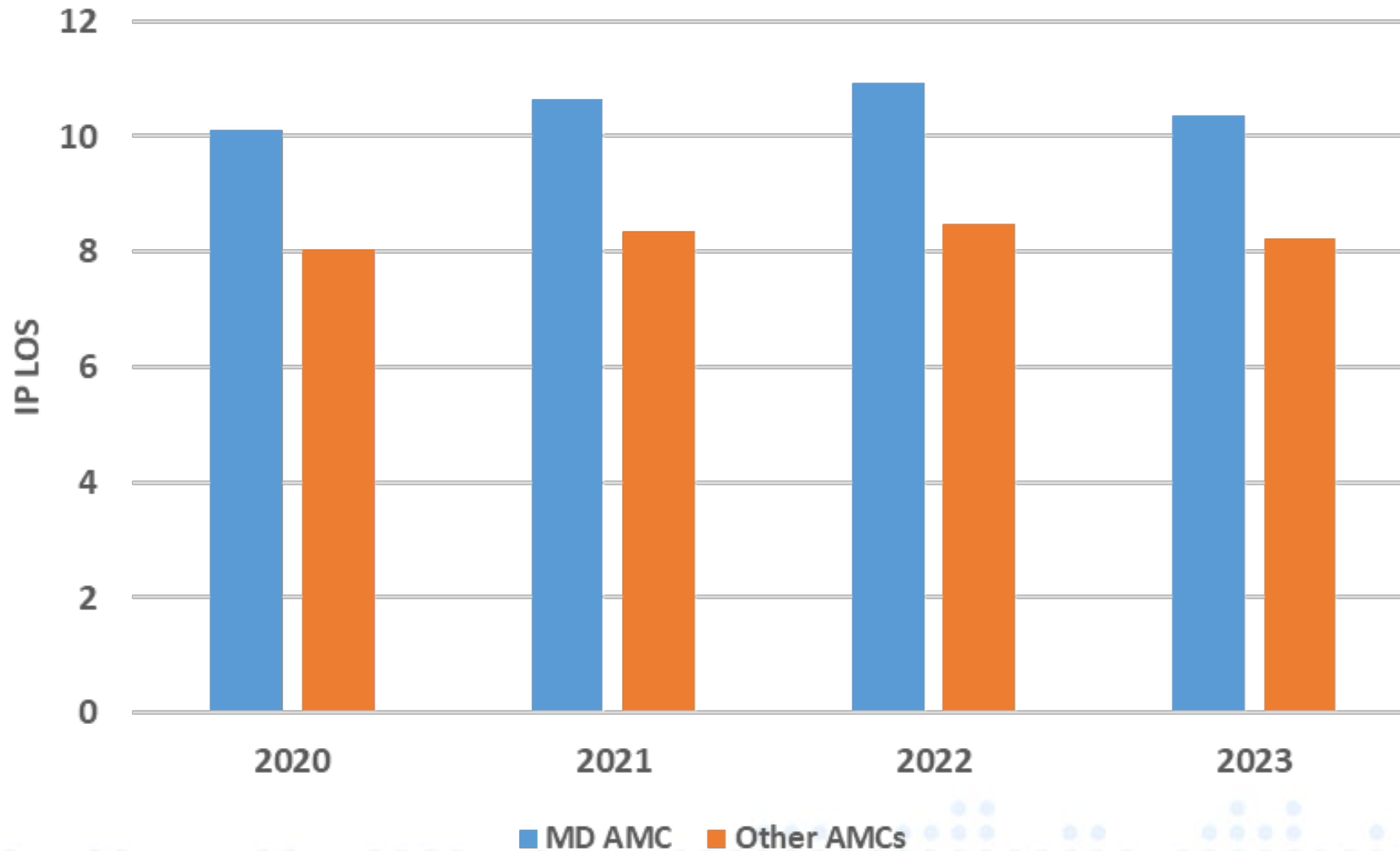
Source: HSCRC Casemix, FY2018-2024

# IP LOS and IP Volume Changes Are Minimally Correlated



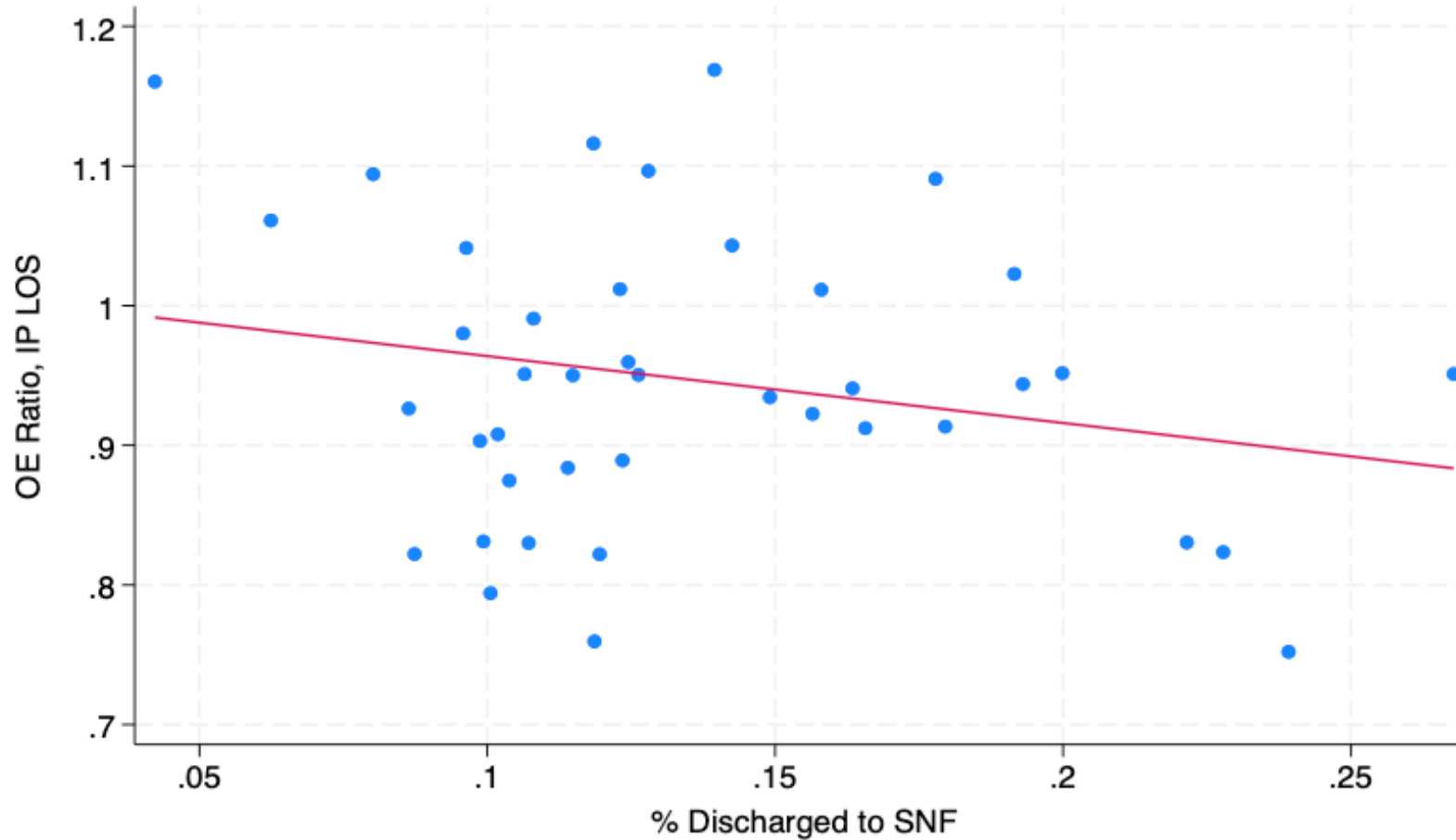
Source: HSCRC Casemix, 2018-2025FY and HCUP 2023 norms adjusting for APR-DRG/SOI

# Maryland AMCs had higher LOS compared to national AMCs



Source: CCW VRDC , Medicare data adjusted by demographic variables, DRG norms and Elixhauser Comorbidity Indices

# IP LOS Is Lower at Hospitals with More Post-Acute Discharges



This suggests operational issues at some hospitals are lengthening IP LOS for patients regardless of discharge destination.

# Measurement Methodology

- Exclusions:
  - Discharges leaving against medical advice
  - Transfers out to other acute care settings
  - Expired cases
  - Shock trauma
  - Chronic and rehabilitation services
  - Unknown discharge dispositions
- Performance will be measured against national averages (expected values) after adjusting for patient risk factors such as diagnosis (APR-DRG), severity of illness (SOI), and payer.
- IP LOS values > 30 days are capped at 30 days to address concerns regarding outliers
- Expected values are estimated using the 2023 HCUP National Inpatient Sample
- Exclude APR-DRG/payer groups that have norms based on <2 cases



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# Final Recommendation for the Inpatient Length of Stay Incentive Program for Rate Year 2028

June XX, 2026

This document contains the final recommendations for the RY 2028 Inpatient Length of Stay Incentive Program.

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## List of Abbreviations

Abbreviation	Definition
AHEAD	Achieving Healthcare Efficiency through Accountable Design
APR-DRG	All Patients Refined Diagnosis Related Groups
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
ED	Emergency Department
FY	Fiscal Year
GBR	Global Budget Revenue
HCUP	Healthcare Cost and Utilization Project
HSCRC	Health Services Cost Review Commission
IP	Inpatient
IP LOS	Inpatient Length of Stay
LOS	Length of Stay
MHA	Maryland Hospital Association
O/E	Observed-to-Expected Ratio
PMWG	Performance Measurement Work Group
RRIP	Readmission Reduction Incentive Program
RY	Rate Year
SNF	Skilled Nursing Facility
SOI	Severity of Illness
TCOC	Total Cost of Care

## Key Methodology Concepts and Definitions

**Diagnosis-Related Group (DRG):** A system to classify hospital cases into categories that are similar in clinical characteristics and in expected resource use. DRGs are based on a patient's primary diagnosis and the presence of other conditions.

**All Patients Refined Diagnosis Related Groups (APR-DRG):** Specific type of DRG assigned using Solventum (formerly 3M) software that groups all diagnosis and procedure codes into one of 328 All-Patient Refined-Diagnosis Related Groups.

**Severity of Illness (SOI):** 4-level classification of minor, moderate, major, and extreme that can be used with APR-DRGs to assess the acuity of a discharge.

**APR-DRG SOI:** Combination of diagnosis-related groups with severity of illness levels, such that each admission can be classified into an APR-DRG SOI "cell" along with other admissions that have the same diagnosis-related group and severity of illness level.

**Case-Mix Adjustment:** National norms for LOS (i.e., normative value or "norm") are derived from the HCUP National Inpatient Sample by APR-DRG/SOI. Expected LOS for each hospital is derived by summing the LOS norms for each patient discharged during the measurement period.

**Observed/Expected (O/E) Ratio:** LOS performance is calculated by dividing the observed LOS by the expected LOS. Expected LOS is determined through case-mix adjustment using national norms.

**Risk-Adjusted LOS:** Observed LOS divided by Expected LOS, multiplied by the National Base Year Mean LOS.

**ED Boarding:** The practice of holding admitted patients in the emergency department after they have been assigned an inpatient bed, typically due to lack of available inpatient beds. ED boarding is a direct consequence of constrained inpatient capacity and prolonged inpatient length of stay.

**Improvement Score:** A measure of change in a hospital's risk-adjusted LOS from the base year to the performance year, expressed as a percentage.

**Attainment Score:** A measure of a hospital's risk-adjusted LOS relative to a fixed threshold, indicating absolute performance rather than improvement.

## Recommendations

These are the final recommendations for the Inpatient Length of Stay Incentive Program (IP LOS):

1. Implement a monitoring program for all-payer inpatient length of stay (IP LOS) for acute-care hospitals.
  - a. Assess the risk-adjusted, mean IP LOS for acute admissions, with clinical exclusions and winsorization to minimize the effect of extreme outlier cases.
  - b. Provide summary level reports and patient level files that allow hospitals to track IP LOS and stratify by patient characteristics (i.e., primary diagnosis, patient disposition) or other factors to identify areas of opportunity.
  - c. Publicly report trends in IP LOS statewide and by hospital at HSCRC Commission meetings.
2. Propose inclusion of IP LOS for payment in RY2029 or RY2030 as part of the portfolio of hospital quality and population health incentives for Maryland Global Budgets (i.e., non-Medicare hospital global budgets).
3. Monitor to ensure the measurement approach is valid and the policy is achieving its intended result (lower IP LOS and ED LOS) and for unintended consequences, including readmission rates and ED revisits.

## Introduction

Maryland hospitals have been and are currently funded under an all-payer global budget revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under agreements with the Centers for Medicare and Medicaid Services (CMS) for the state to operate the All-Payer Model (Calendar (CY) 2014- CY 2018), the Total Cost of Care (TCOC) Model (CY 2019-CY 2025), and the current AHEAD model (CY 2026- CY 2035). Maryland's global budget system, which provides hospitals with annual prospective budgets, guarantees Maryland hospitals a greater source of financial stability and provides incentives to shift services to the most appropriate care setting and reduce potentially avoidable utilization. The HSCRC adjusts hospital global budgets for quality of care and patient experience through pay-for-performance policies that assess areas of national focus (e.g., hospital acquired complications, readmissions) and areas of opportunity that are unique to Maryland and global budgets. HSCRC also monitors and publicly reports measures for key areas of interest, including areas under consideration for future payment policy.

The Inpatient Length of Stay (IP LOS) Policy is being proposed to the Commission to address concerns related to significant post-pandemic growth in IP LOS at Maryland hospitals. Extended hospital stays are sometimes unavoidable. In other instances, patients remain hospitalized for longer than necessary due to ineffective initial treatment, poor discharge planning, or other hospital-specific factors. This can result in

poor patient outcomes and financially strained healthcare institutions. Prolonged inpatient LOS, and the resulting reduction in available open inpatient beds, is also a key factor in extended emergency department LOS. Currently, Maryland's emergency departments are among the most crowded in the nation, and managing IP LOS is a critical piece of managing this issue.

While the majority of Maryland hospitals are at or below the national average for IP LOS, incentives in this area are still needed. Maryland has fewer inpatient beds per capita than most states, so absent better performance on IP LOS, hospitals may experience bed capacity issues. Additionally, implementation of an IP LOS policy counterbalances the incentives of the surge policy, which provided emergency funding to support extreme patient loads during the winter respiratory illness season. Without such a counterweight, it is possible that the surge policy would result in worsening IP LOS that would place more Maryland hospitals above the national average.

Policy development for this and other State hospital incentive programs is vetted with stakeholders and approved by the Commission to ensure the programs strike a balance between driving needed changes and avoiding unanticipated consequences. For purposes of the RY 2028 IP LOS Policy, staff vetted the potential recommendations with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies. Based on stakeholder input, and given the current transition to the National quality programs, staff propose to monitor IP LOS for RY2028 and revisit payment options in RY2029 or RY2030 in conjunction with the transition to Maryland quality programs (i.e., programs impacting hospital global budgets for non-Medicare FFS patients).

## Background

One of the central motivations for this policy is a paradox that has emerged in Maryland hospital utilization trends: even as the number of inpatient admissions have declined—an outcome consistent with the goals of global budgets and Total Cost of Care accountability—overall inpatient utilization, as measured by total bed-days, has increased. This divergence arises because reductions in admission volume have been more than offset by increases in the average length of each stay. The result is that hospitals are caring for fewer patients in aggregate, but those patients are occupying beds for longer periods, consuming proportionally more capacity per episode of care.

This dynamic has direct implications for the financial sustainability of the AHEAD model. Global Budget Revenue is premised on the idea that hospitals can manage both the volume and the intensity of inpatient utilization with fixed funding. When bed-days rise even as admissions fall, it signals that inpatient resources are not being freed up at the rate the model anticipates. Hospitals operating with elevated LOS face constrained physical capacity, which in turn limits their ability to respond to surges in demand, coordinate effectively with post-acute partners, and avoid the boarding of admitted patients in the emergency department. In short, declining admission volume is a necessary but not sufficient condition for model

sustainability—it must be accompanied by a proportional reduction in LOS to translate into genuine efficiency gains. The IP LOS incentive is designed to close this gap by targeting the dimension of inpatient utilization that has, to date, been moving in the wrong direction.

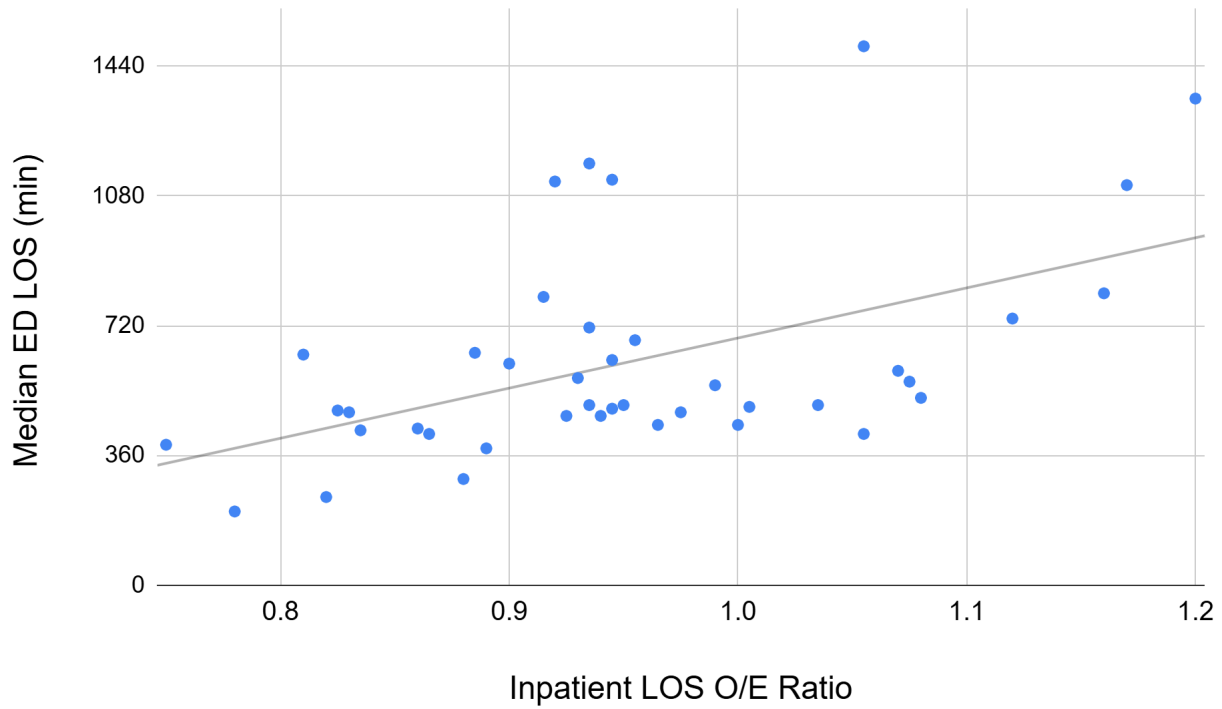
While incentives exist to improve IP LOS through global budgets and TCOC accountability, those incentives have not prevented marked growth in IP LOS. Thus, staff believe a policy focused explicitly on IP LOS, similar to RRIP for readmissions, is necessary to optimize care delivery and accelerate progress toward national norms. This is particularly true now that the recently approved surge policy provides incentives based, in part, on bed-days, which could potentially result in further increases in IP LOS.

## **Impact on Emergency Department Length of Stay**

One of the primary rationales for implementing an IP LOS policy is its potential impact on emergency department operations. When inpatient beds are occupied by patients with prolonged stays, the hospital's capacity to admit new patients from the emergency department is constrained. This creates a "backup" effect where admitted patients must wait—or "board"—in the ED until an inpatient bed becomes available. This boarding accumulation leads to longer wait times for all ED patients, delayed treatment for new arrivals, ambulance diversion, increased patient safety risks, staff burnout and reduced quality of care.

In Maryland, the correlation between IP LOS and ED LOS at the hospital level is 0.5 (Figure 1), indicating moderate correlation. Because of this relationship, as well as the clear operational linkage between IP LOS and ED boarding, staff concluded that achieving the policy's multi-year goal of bringing IP LOS at all Maryland hospitals toward the national average could result in significant reductions in ED boarding hours, improved ED throughput, enhanced patient experience, and better clinical outcomes.

**Figure 1. Inpatient and ED Length of Stay for Admitted Patients By Hospital, FY2025**



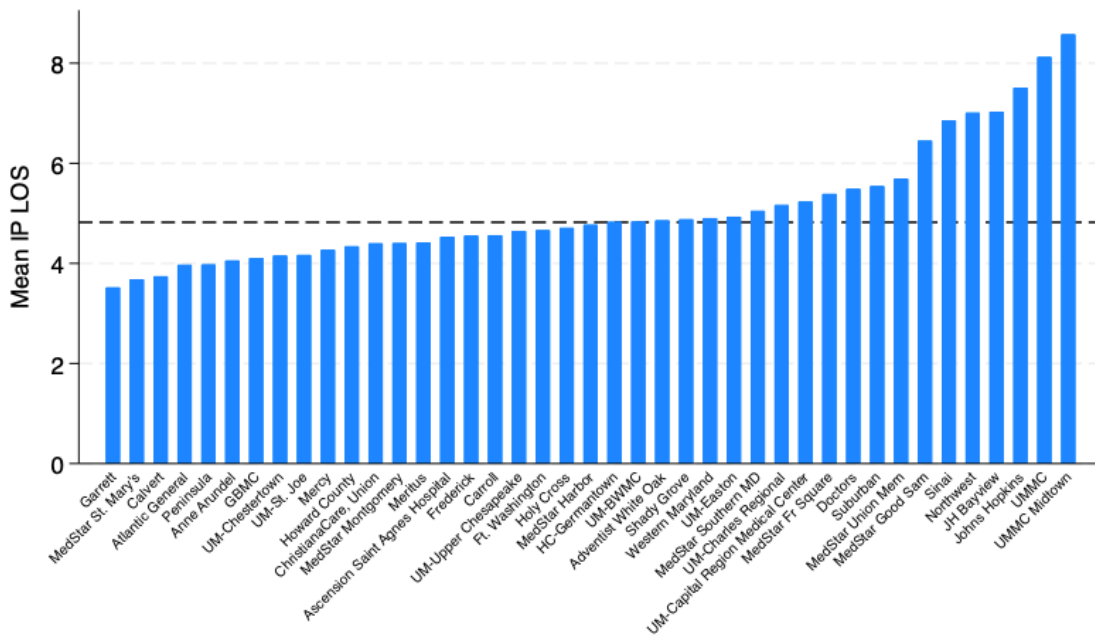
Source: FY25 IP LOS OE & HCUP 2023 norms adjusting for APR-DRG/SOI vs ED Median LOS, 2025

## Maryland Hospital Performance

The following section provides an overview of Maryland hospital performance on IP LOS, evaluation of factors that may account for longer IP LOS, and addresses questions and concerns raised by stakeholders.

Staff evaluated IP LOS of Maryland hospitals against the national average using data from the Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample, a representative sample of discharge records from non-federal acute-care U.S. hospitals maintained by the federal Agency for Healthcare Quality and Research. The most recent survey data is from 2023. In FY2025, patients at 20 of the State's acute-care hospitals experienced IP LOS longer than the most recently available national average (Figure 2), with the highest mean LOS at a Maryland hospital more than 75% higher than the national average.

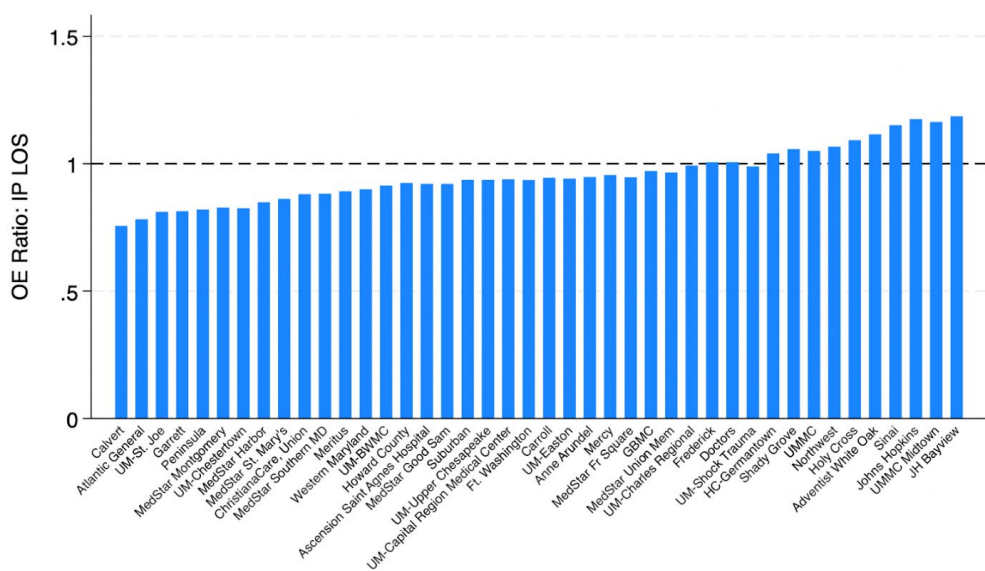
Figure 2. Mean IP LOS of Maryland Hospitals, FY2025



Source: HSCRC FY2025 Casemix

To gauge whether this comparison was impacted by differences in patient acuity between Maryland hospitals and those elsewhere, staff indirectly standardized the IP LOS of Maryland hospitals using national norms by APR-DRG, severity of illness and payer derived from the NIS. In the risk-adjusted analysis, one quarter of Maryland hospitals continued to have IP LOS higher than the national average (Figure 3). More than 38 percent of the state's hospital stays occur at facilities with IP LOS higher than the national average. Staff assessed the degree to which hospital performance was influenced by including in the analysis norms calculated on a patient group of less than 30, which can occur when there are few patients in the NIS with a particular combination of APR-DRG, severity indicator and payer. The OE ratios calculated after excluding cells with fewer than 30 patients were correlated at >0.99 with the original ratios, leading staff to conclude that small cell size was not a source of measurement error.

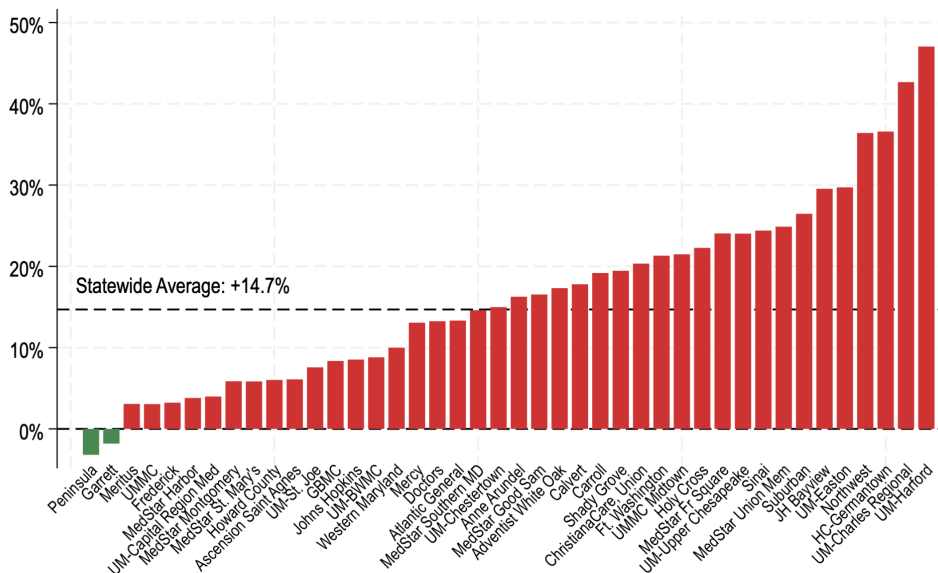
**Figure 3. IP LOS Observed/Expected Ratios for Maryland Hospitals, FY2025**



Source: HSCRC FY2025 Casemix, risk adjusted for APR-DRG, and payer using 2023 HCUP norms

The performance of Maryland hospitals in FY2025 followed several years of increasing LOS. Between 2018 to 2024, IP LOS at most hospitals in the State increased more than 10%, while some increased more than 20%. Only two of the State's hospitals experienced decreases during the period (Figure 4).

**Figure 4. Change in IP LOS for Maryland Hospitals, FY2018-2024**



Source: HSCRC Casemix, FY2018-2024

## Evaluation of Factors Leading to Longer IP LOS

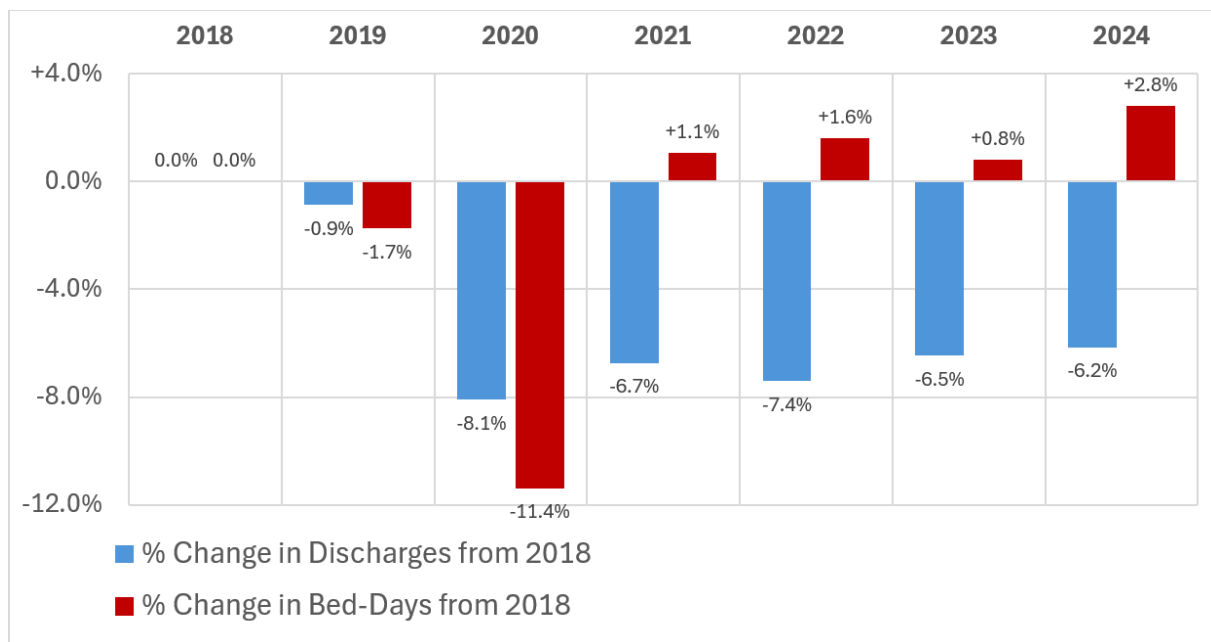
There are several potential reasons for rising IP LOS, including some related to factors largely beyond the control of hospitals. Staff evaluated these explanations empirically to ensure that the policy incentivizes an outcome that is meaningfully responsive to hospital-led interventions.

One leading explanation is that the shift in IP LOS was the result of TCOC Model dynamics, in that incentivizing a reduction in inpatient discharges directed a sizable population of low-acuity patients from inpatient services to lower-acuity settings. This would result in a longer average LOS for the remaining patients due to their higher acuity.

Staff expected that if this theory were correct, Maryland’s performance would fall in line with that of the nation after risk adjustment. However, while implementation of risk adjustment moved some Maryland hospitals in line with the national average, a significant portion of facilities remained above the national average.

To address the possibility that this risk-adjustment approach was not completely effective in controlling for patient acuity, staff evaluated the statewide change in both IP discharges and IP bed-days over time. If the IP LOS issue were driven by removal of the low-acuity population, we would expect to see discharges fall with a corresponding small decrease in bed-days. Instead, there was a net gain in statewide bed-days over time, indicating that utilization for higher-acuity patients increased (Figure 5).

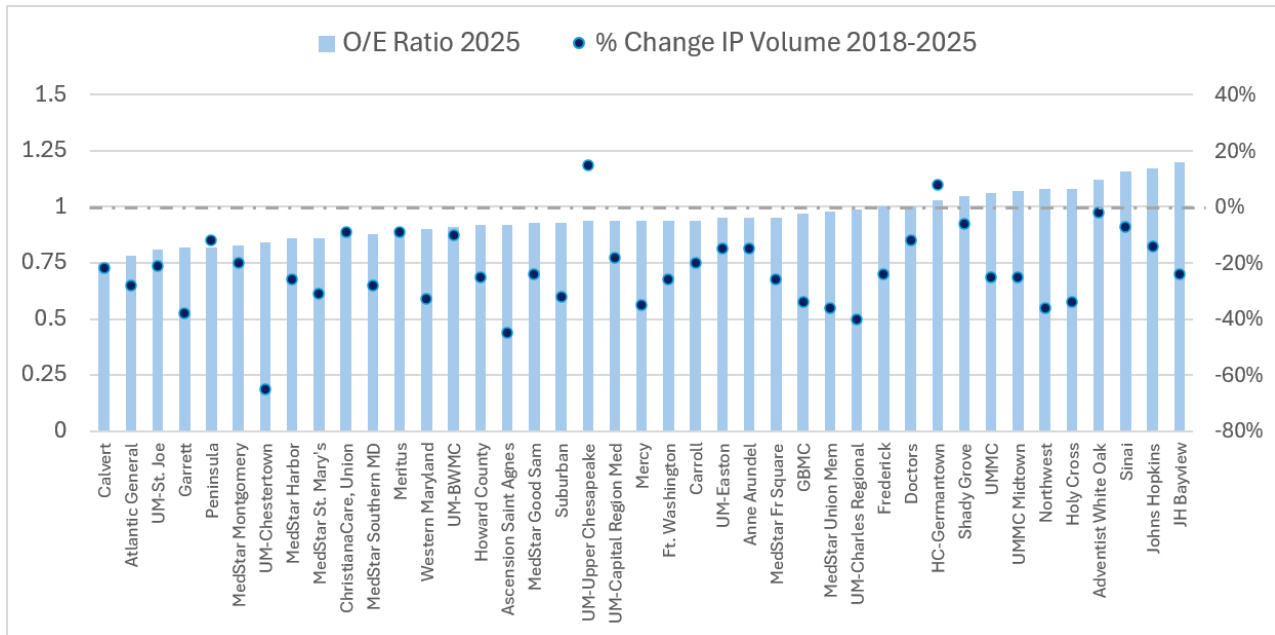
**Figure 5. Patient Bed-Days vs. Observation and Inpatient Discharges, FY2018-2024**



Source: HSCRC Casemix, FY2018-2024

Staff also evaluated the association between inpatient volume changes and CY2025 IP LOS performance. If the shift to lower-acuity settings was behind rising IP LOS, one would expect that the hospitals with the largest volume decreases would have the highest risk-adjusted IP LOS. However, the analysis indicated that IP LOS and volume changes are minimally correlated (Figure 6).

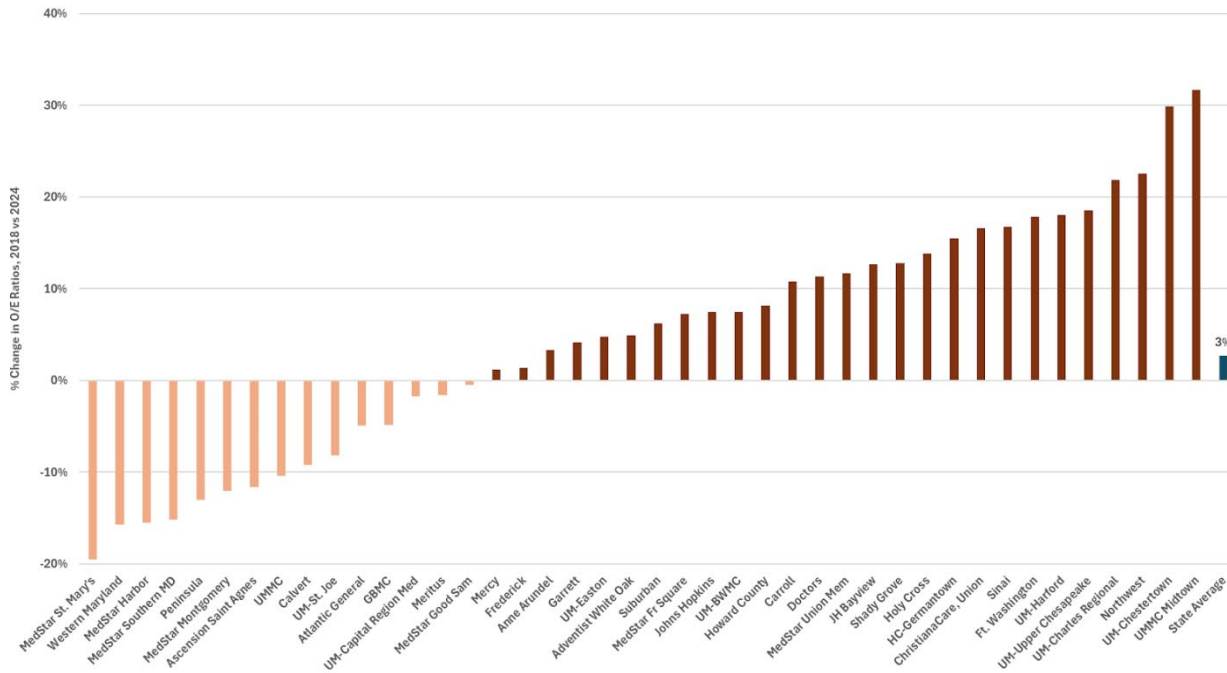
**Figure 6. Association Between FY 2025 Inpatient Length of Stay and Volume Changes, 2018-2025**



Source: HSCRC Casemix, 2018-2025FY and HCUP 2023 norms adjusting for APR-DRG/SOI

Finally, staff identified several cohorts of patients, including those undergoing heart bypass and other major surgery, whose care has been consistently delivered on inpatient services for the duration of the TCOC Model. Staff hypothesized that if the growth in low-acuity unregulated care were responsible for rising IP LOS, these cohorts would exhibit stable LOS over time. However, significant increases in IP LOS were observed in these inpatient-only cohorts (Figure 7).

Figure 7. Change in IP LOS By Hospital for Inpatient-Only Procedures, 2018 vs 2024 FY

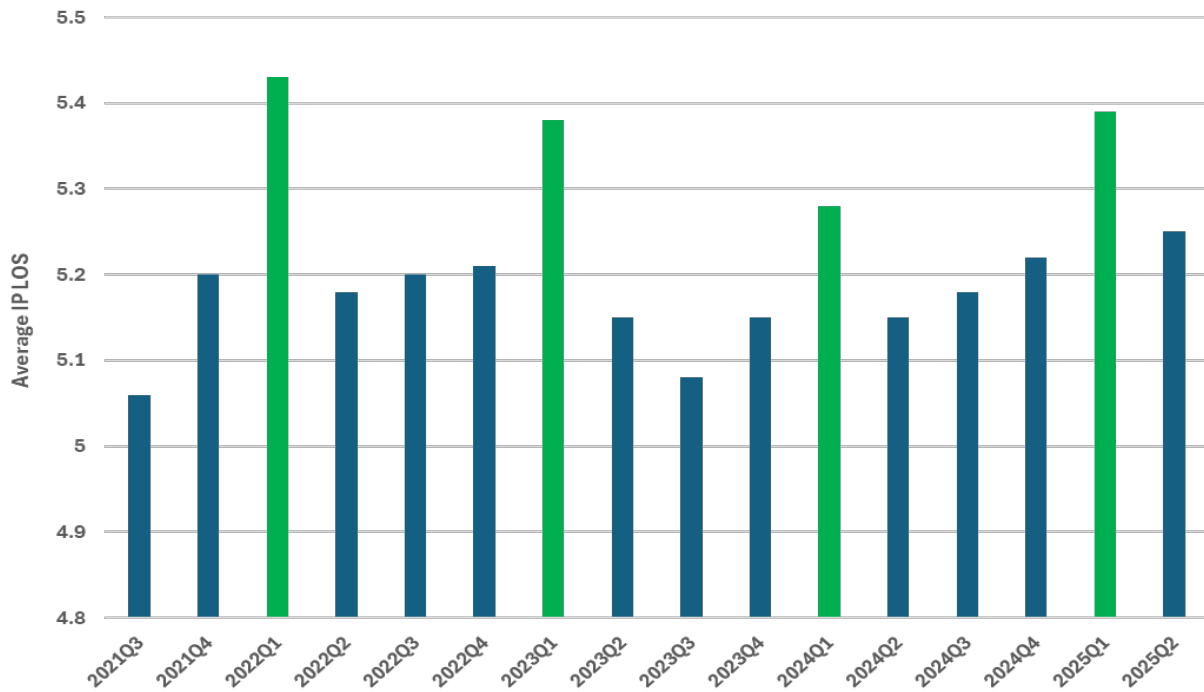


Source: HSCRC Casemix, 2018-2024 FY, risk adjusted by HCUP 2023

Another possibility is that payment practices specific to government insurance programs drive increasing IP LOS. Staff evaluated this theory by comparing hospital IP LOS performance by payer. This analysis indicated that hospitals with risk-adjusted LOS longer than the national average perform similarly regardless of payer, indicating that the issue is likely not related to payer policies.

An additional theory is that the TCOC Model created incentives for hospitals to unnecessarily lengthen LOS at the close of the fiscal year to avoid falling under global budget revenue targets. Staff evaluated this by reviewing quarterly changes in IP LOS for the past several years. This analysis (Figure 8) indicated that there is marked variation in IP LOS by quarter. However, the longest LOS regularly occurs in the first quarter of the calendar year, when respiratory illnesses peak. The second quarter, which coincides with the close of the rate year, typically sees the lowest IP LOS of the year.

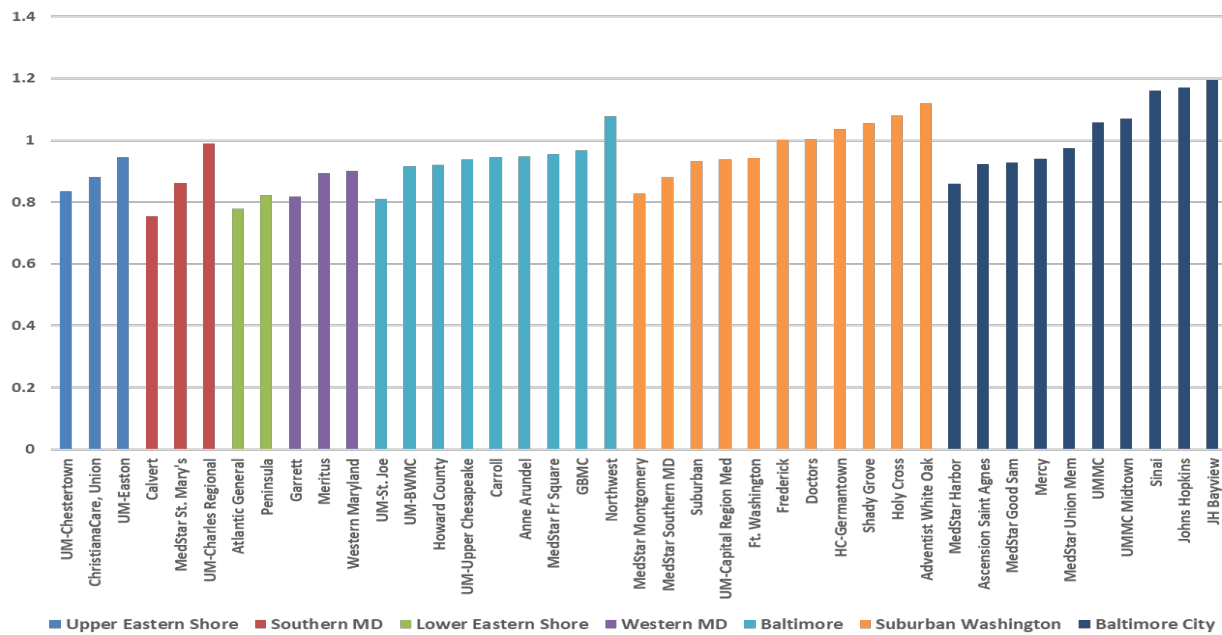
Figure 8. Variation in Inpatient Length of Stay by Calendar-Year Quarter



Source: HSCRC Casemix data, FY2022 - FY2025

Staff also investigated the possibility that IP LOS is associated with differences among patients and within hospitals operating in low-income environments. Risk-adjusted hospital IP LOS was evaluated for each of the state's seven regions. While rural areas generally had lower IP LOS, three of the state's regions, including the affluent Suburban Washington area, contained hospitals with risk-adjusted IP LOS above the national average.

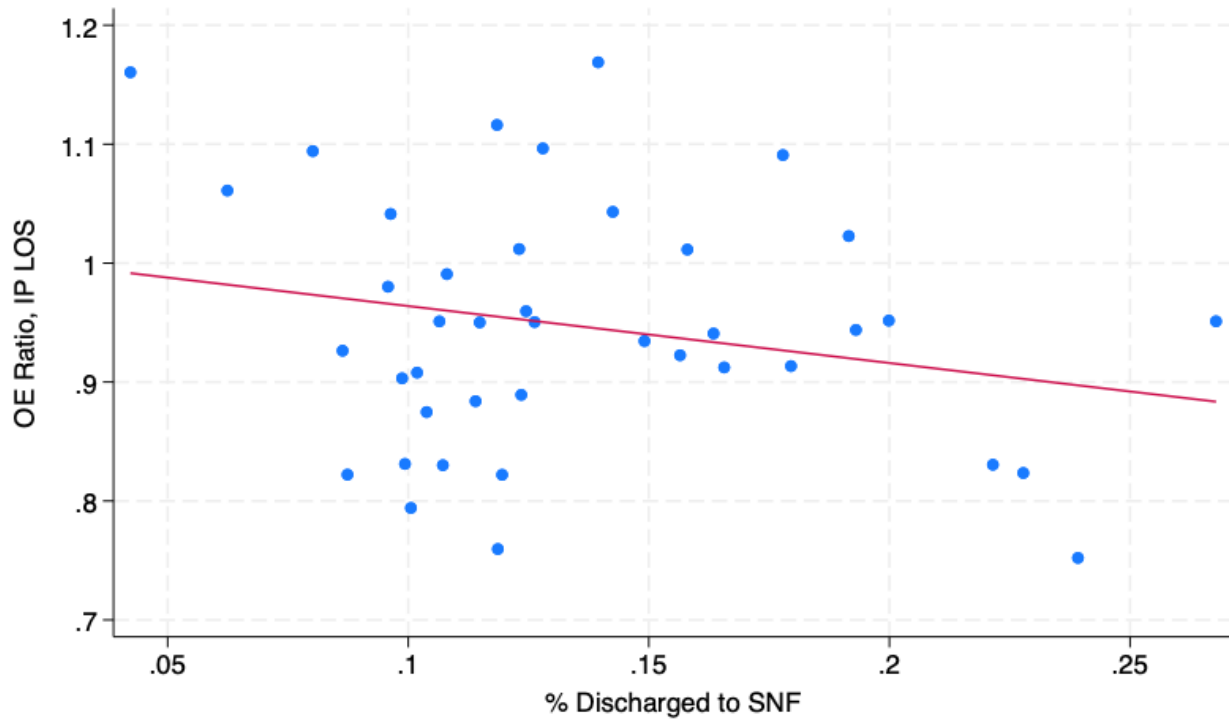
Figure 9. Risk-Adjusted Hospital IP LOS By Region, 2025



Source: 2025 HSCRC Casemix, HCUP 2023 norms adjusting for APR-DRG/SOI (Severity of Illness)

Staff also considered whether post-acute care availability was responsible for elevated IP LOS. Statewide, patients discharged to post-acute care have IP LOS above the national average, while those discharged elsewhere have IP LOS below the national average. However, at the hospital level, IP LOS is minimally (and inversely) correlated with volume of post-acute discharges. This suggests that operational issues at some hospitals are lengthening LOS for patients regardless of discharge destination, and that the IP LOS policy could improve efficiency and patient experience at these facilities.

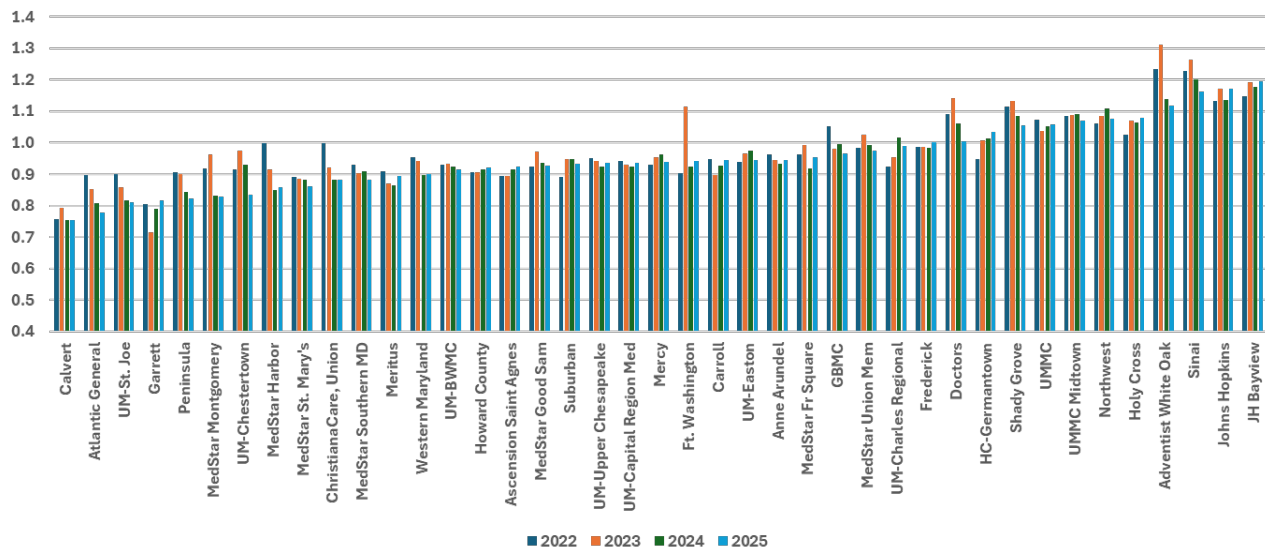
Figure 10. Risk-Adjusted Hospital IP LOS vs. Percent of Patients Discharged to SNF, 2025



Source: CY2025 HSCRC Casemix, HCUP 2023 norms adjusting for APR-DRG/SOI (Severity of Illness)

A final possibility is that the performance of Maryland hospitals as compared to the nation is the result of random variation rather than differences in hospital operations. However, an analysis of risk-adjusted hospital performance over time indicated that hospitals performing below the national average in CY2025 experienced similar performance in prior years (Figure 11). Because of this, staff concluded that the factors driving elevated LOS are related to hospital operations rather than random variation.

Figure 11. Annual Variation in IP LOS, CY2022-2025



Source: 2025 HSCRC Casemix, HCUP 2023 norms adjusting for APR-DRG/SOI (Severity of Illness)

After evaluating several potential causes of rising IP LOS that are unrelated to hospital performance, as well as information on a number of successful hospital-led IP LOS interventions described in peer-reviewed literature, staff concluded that hospital operations are a significant factor in IP LOS, and that a policy incentivizing improvements in IP LOS would benefit patients, hospitals, and the State's healthcare system.

## Measurement and Incentives Overview

This section provides an overview of the IP LOS performance measure. Due to the significant uncertainty around the structure and operational impact of changes to HSCRC policies under the AHEAD model, staff recommends monitoring of the measurement component of the IP LOS policy for RY2028. Additionally, staff recommends integration of IP LOS measure into the RY2029 or RY2030 quality programs, which will adjust the Maryland hospital global budgets (i.e., non-Medicare FFS global budgets set by HSCRC). Staff recommend that IP LOS be adopted as part of the portfolio of hospital quality and population health pay-for-performance incentives with the total revenue at-risk for this portfolio not to exceed the Medicare incentives. This includes consideration of this incentive under the maximum revenue guardrail policy. Additional discussion of incentive details may be found in Appendix A.

## Performance Metric

### Measurement

The policy will measure all-payer risk-adjusted inpatient length of stay (IP LOS) for acute-care hospitals.

## Proposed Exclusions

The following discharge types are excluded from measurement:

Exclusion Category	Rationale
Discharges leaving against medical advice	Patient-driven departure, not reflective of hospital performance
Transfers out	LOS attributed to receiving hospital
Expired cases	Clinical outcomes measure, not LOS efficiency
Shock trauma and discharges from long term care beds	Unique clinical circumstances not comparable to general admissions
Unknown discharge dispositions	Data quality concern

## Risk-Adjustment Methodology

Expected LOS will be calculated as the average LOS by APR-DRG, SOI, and payer (Commercial, Medicare, Medicaid, Other) from the 2023 HCUP National Inpatient Sample. Total Observed IP LOS will be calculated as the sum of the actual observed LOS (capped at 30 days) for each patient discharged during the measurement period. Total Expected IP LOS for each hospital is derived by summing the Expected LOS for the same patients. The performance metric is the total Observed IP LOS divided by the total Expected IP LOS (O/E Ratio). Hospitals that performed at the same level as the nation will have an O/E Ratio of 1. An O/E Ratio of <1 indicates better performance while a ratio > 1 indicates worse performance compared to the national benchmarks. While the O/E ratio is often multiplied by the unadjusted average from the reference population to obtain the risk-adjusted average, the pay-for-performance methodology proposed here will use the O/E ratio.

## Stakeholder Feedback

Comment letters on the Draft IP LOS Policy were received from Health Means Everything Consumer Alliance (HME), the Maryland Hospital Administration (MHA), Adventist Health, Frederick Health, Johns Hopkins Health System (JHHS), Lifebridge Health, Luminis Health, MedStar Health, and the University of Maryland Medical System (UMMS). Letters expressed several concerns about the draft policy and made

suggestions for improvements. Several commenters argued that the aims of the Policy were already sufficiently incentivized by other HSCRC Policies, that the Policy did not adequately account for patient risk-profiles (particularly among academic medical centers), that the Policy would punish hospitals for structural barriers outside of their control, that the IP LOS Policy would interfere with implementation of the AHEAD model, and that the timeline of the Draft Policy was overly aggressive. Figure 16 provides an overview of the comments received and is followed by a discussion of the feedback along with staff responses.

**Figure 16. Summary of Stakeholder Comment Letters**

Stakeholder Comment Letters for RY 2028 IP LOS	Adventist HealthCare	Frederick Health	HME	JHHS	LifeBridge Health	Luminis Health	MedStar	MHA	UMMS
Redundant to Incentives in GBR and QBR	X			X		X	X	X	X
Misalignment with the AHEAD Model	X	X		X	X	X	X	X	X
External Factors Outside of Hospital Control	X	X		X	X	X	X	X	X
Inadequate Risk Adjustment	X			X	X	X	X	X	X
Need for Monitoring to Avoid Unintended Consequences			X	X				X	
Timing of Policy Implementation	X	X		X	X	X	X	X	X

**Redundancy of the IP LOS Policy Due to Incentives Already in Place through GBR and QBR:**

Adventist, JHHS, Luminis Health, MedStar, MHA, and UMMS questioned the need for an IP LOS policy given the incentives already in place under the Maryland Model. Adventist and UMMS additionally raised concerns about additional revenue-at-risk under the IP LOS policy.

**Staff Response:** While the current model does incentivize managing IP LOS, the rapid increase in IP LOS in recent years indicates that existing incentives have not been clear enough to prevent this growth. The IP LOS policy will be “monitoring-only” for RY 2028. If incentives are introduced in subsequent rate years, they will be included as part of the current revenue at risk for hospital quality and population health (i.e., part of the 6 percent at-risk) and be included under the maximum revenue guardrail policy.

**Difficulty with Alignment to AHEAD:** Adventist, Frederick, JHHS, LifeBridge, Luminis, MedStar, MHA, and UMMS argued that resources were better directed towards implementing the AHEAD model rather than creating state-specific policies.

**Staff Response:** While staff appreciate the difficulties of navigating the AHEAD transition, the magnitude of the State’s current issues with ED overcrowding and growth in IP LOS requires immediate action. IP LOS has increased rapidly, and if this growth continues, it would likely threaten the financial viability of the AHEAD model.

**Influence of Systematic Issues Beyond Hospital Control and Outliers:** Adventist, Frederick, JHHS, Luminis Health, MedStar, MHA, and UMMS argued that deficits in post-acute bed capacity, payer authorization delays, and patient social factors contribute to prolonged LOS and are outside of the hospital's control. Adventist, Frederick, and UMMS additionally recommended that the IP LOS policy focus only on patients discharged to their homes.

**Staff Response:** Staff acknowledge that patients who are discharged to post-acute care have longer IP LOS than patients discharged home. However, we also found that hospitals with a higher percentage of post-acute discharges also tended to have better performance on the IP LOS measure, suggesting it is possible to develop efficient discharge workflows under current capacity. We found that hospitals with prolonged LOS on patients discharged to post-acute settings also tended to have prolonged LOS on patients discharged home, pointing to hospital-level factors driving IP LOS performance rather than external factors. Additionally, excluding patients discharged to post-acute settings would have negative policy implications and remove an opportunity for hospitals to improve quality of care for all of their patients. We will stratify IP LOS reporting by discharge destination and staff will monitor for unintended consequences and propose policy changes as necessary.

**Methodology for Risk Adjustment:** Adventist, JHHS, LifeBridge, Luminis, MedStar, MHA, and UMMS raised concerns about the proposed risk-adjustment methodology, including the use of HCUP data to establish national benchmarks, and lack of adjustment for social and legal factors that may contribute to prolonged LOS. JHHS and UMMS additionally argued that the proposed methodology did not adequately account for the patient complexity at AMCs.

**Staff Response:** The proposed risk-adjustment methodology is similar to the approaches used in the Commission-approved RRIP, MHAC, and QBR policies. The APR-DRG system and SOI were specifically designed to address differences in utilization outcomes like LOS across hospitalizations. The HCUP survey is also designed to be representative of discharges from all non-federal acute-care hospitals in the US, and includes data from AMCs as well as behavioral health and complex medical cases. We have also amended the policy to cap each individual patient's stay at 30 days for the purposes of calculating a hospital's average LOS to minimize the effect of these outlier cases..

**Need for Monitoring to Avoid Unforeseen Consequences:** HME, JHHS, and MHA raised concerns about potential unintended consequences of the draft IP LOS policy; HME recommended (1) monitoring for premature discharge, particularly for elderly patients and those with complex medical or behavioral health needs; (2) working with insurers and providers to ensure safe discharges, and (3) publicly reporting on program performance to allow consumers to make informed healthcare decisions.

**Staff Response:** Staff agrees that managing IP LOS could result in premature discharges. However, existing quality programs, including RRIP and QBR, will likely detect any of these unintended

consequences. Staff set the revenue-at-risk for the IP LOS policy to be lower than revenue-at-risk for RRIP specifically to avoid this issue.

**Timing of Policy Implementation:** All of the hospital systems raised concerns about the timing of the policy implication; the draft policy designated 2026 as the performance period for RY 2028, but the policy would not be finalized until June of 2026, half way through the performance period.

**Staff Response:** Staff have recommended changing the policy to monitoring-only for RY 2028 and introducing financial penalties and rewards starting in RY 2029 or RY 2030. We will also monitor the policy to ensure the intended result (lowering of ED LOS and IP LOS) is achieved and to surveil for unintended consequences, including increased readmissions and ED revisits.

## Recommendations

These are the final recommendations for the Inpatient Length of Stay Incentive Program (IP LOS):

1. Implement a monitoring program for all-payer inpatient length of stay (IP LOS) for acute-care hospitals.
  - a. Assess the risk-adjusted, mean IP LOS for acute admissions, with clinical exclusions and winsorization to minimize the effect of extreme outlier cases.
  - b. Provide summary level reports and patient level files that allow hospitals to track IP LOS and stratify by patient characteristics (i.e., primary diagnosis, patient disposition) or other factors to identify areas of opportunity.
  - c. Publicly report trends in IP LOS statewide and by hospital at HSCRC Commission meetings.
2. Propose inclusion of IP LOS for payment in RY2029 or RY2030 as part of the portfolio of hospital quality and population health incentives for Maryland Global Budgets (i.e., non-Medicare hospital global budgets).
3. Monitor to ensure the measurement approach is valid and the policy is achieving its intended result (lower IP LOS and ED LOS) and for unintended consequences, including readmission rates and ED revisits.

## Appendix A: Potential Structure of Incentive Program

This section presents details on how financial incentives for IP LOS performance could be structured for inclusion in RY 2029 or RY 2030 payment policy.

### Performance Targets

Performance targets are modeled similarly to how the targets for the Readmission Reduction Incentive Program were established. Specifically, hospitals will be assessed on both improvement in IP LOS from a fixed base period and actual performance (i.e., attainment) relative to the nation during each performance year. Below are the improvement and attainment targets established based on modeling of opportunity and stakeholder feedback.

### Improvement Targets

Figure 12 provides a range of improvement scenarios that were considered and the proposed improvement goal for CY2023 through CY2028. Given this is a new policy, staff believes the improvement goal should both consider what is required to have all hospitals reach the national average, as well as historical performance over time to avoid setting an overly aggressive goal that could lead to unintended consequences. Based on stakeholder feedback, a set base period of CY2023 will be used for measuring improvement in CY 2026. Staff propose a cumulative improvement of 5 percent over 5-years (CY2023-CY2028) based on historical trends and the goals set forth in this policy.

Figure 12. Improvement Scenario Options

#	Estimating Method	Percent Improvement	Annualized Improvement	CY2026 Improvement Threshold
1	Statewide improvement, CY2023-CY2025	-1.05%	-0.21%	-0.63%
2	Mean hospital improvement, CY2023-CY2025	-1.26%	-0.25%	-0.76%
3	Mean hospital improvement among hospitals with reductions, CY2023-CY2025	-3.72%	-0.75%	-2.25%
4	Statewide change if all hospitals with an O/E Ratio greater than 1, improve to 1 in CY 2023	-4.35%	-0.89%	-2.63%
5	Statewide change if all hospitals with an O/E Ratio greater than 1, improve to statewide median in CY2023	-6.56%	-1.35%	-3.99%
6	Improvement from the mean O/E ratio of those greater than 1 in CY2023 to 1	-8.77%	-1.82%	-5.36%
<b>Proposed Improvement Goal</b>		<b>-5.00%</b>	<b>-1.02%</b>	<b>-3.03%</b>

Using the 5 percent improvement goal, Figure 13 shows the proposed improvement scale for scaling revenue adjustments based on CY2023 to CY2026 performance. The threshold of -3.03 percent is the improvement needed to avoid being penalized. The maximum penalty was set at the mean improvement for the worst decile of improvement from CY 2023 to CY 2025. The maximum reward was linearly extrapolated from the threshold and the maximum penalty.

Figure 13. Improvement Scale

LOS % IP Revenue Payment Adjustment		LOS % IP Revenue Payment Adjustment
<b>Improving</b>	<b>-10.22%</b>	<b>0.50%</b>
	-9.50%	0.45%
	-8.78%	0.40%
	-8.06%	0.35%
	-7.34%	0.30%
	-6.63%	0.25%
	-5.91%	0.20%
	-5.19%	0.15%
	-4.47%	0.10%
	-3.75%	0.05%
<b>Threshold</b>	<b>-3.03%</b>	<b>0.00%</b>
	-2.31%	-0.05%
	-1.59%	-0.10%
	-0.87%	-0.15%
	-0.15%	-0.20%
	0.56%	-0.25%
	1.28%	-0.30%
	2.00%	-0.35%
	2.72%	-0.40%
	3.44%	-0.45%
<b>Worsening</b>	<b>4.16%</b>	<b>-0.50%</b>

## Attainment Targets

Figure 14 provides the proposed attainment scaling. The attainment threshold is set at O/E Ratio of 1 from CY 2023, adjusted for the improvement threshold determined above. While the attainment threshold could be set at the O/E ratio of 1.0, staff have historically included the improvement goal into the attainment standards for readmissions to further emphasize improvement. The attainment benchmark (i.e., O/E ratio where hospitals could receive full reward) was set at the average of the top performing decile of hospitals in CY2023 plus the improvement target.

Figure 14. Attainment Scale

LOS % IP Revenue Payment Adjustment	LOS % IP Revenue Payment Adjustment
<b>Improving</b>	<b>0.50%</b>
	0.45%
	0.40%
	0.35%
	0.30%
	0.25%
	0.20%
	0.15%
	0.10%
	0.05%
<b>Threshold</b>	<b>0.00%</b>
	-0.05%
	-0.10%
	-0.15%
	-0.20%
	-0.25%
	-0.30%
	-0.35%
	-0.40%
	-0.45%
<b>Worsening</b>	<b>-0.50%</b>

## Revenue Adjustment Modeling

Figure 15 provides statewide revenue adjustments using the parameters set above and CY2025 data as a proxy for CY2026 performance. Given that the majority of hospitals perform better than the national average, the net statewide adjustments are +0.3 percent (estimated at +\$3.6 million). Of the 40 hospitals included in the policy, 11 would be penalized a total of 0.08 percent due to increases in IP LOS or improvements less than the improvement threshold and O/E ratios greater than attainment threshold (estimated at -\$9.4 million). By hospitals modeling is provided in Appendix B and an excel modeling workbook has been provided to stakeholders and can be provided upon request.

**Figure 15. Statewide Revenue Adjustment, Base 2023 vs CY 2026 (CY 2025 used as proxy)**

Summary			
Statewide Revenue		\$12,379,325,935	
\$ Better of Attainment/ Improvement	Rewards (29 Hosp.)	\$13,017,011	Statewide Percent: 0.11%
	Penalties (11 Hosp.)	(\$9,392,283)	Statewide Percent: -0.08%
Net Revenue Adjustment		\$3,624,728	Statewide Percent: 0.03%

## AHEAD Model Considerations

Staff will discuss inclusion of the IP LOS revenue adjustment in the CMS HGBs. If this is not possible, staff will update the policy so that all-payer performance is used to adjust revenue for State HGBs for non-Medicare revenue.

## Appendix B: By Hospital Modeling

Modeling of Revenue Adjustments by Hospital (05/26/2026)					Improvement Scaling			Attainment Scaling			Final Adjustment				
HO SPITAL ID	HO SPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue**	Base 2023	CY 2026 (CY 2025 used as proxy)	Percent change	Target	% Revenue Adjustment	\$ Revenue Adjustment	CY 2026 (CY 2025 used as proxy)	Target (national average + improvement)	% Revenue Adjustment	\$ Revenue Adjustment	\$ Better of Attainment or Improvement	FY 25 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment
210001	Meritus	\$307,533,751	0.8568	0.8921	3.91%	-3.03%	-0.48%	-\$1,476,162	0.8921	0.9697	0.21%	\$645,821	\$645,821	0.21%	Att
210002	UMMC	\$1,667,872,778	1.0388	1.0605	2.11%	-3.03%	-0.36%	-\$6,004,342	1.0605	0.9697	-0.25%	-\$4,169,682	-\$4,169,682	-0.25%	Att
210003	UM-Capital Region Med	\$334,294,899	0.9446	0.9792	3.67%	-3.03%	-0.47%	-\$1,571,186	0.9792	0.9697	-0.03%	-\$100,288	-\$100,288	-0.03%	Att
210004	Holy Cross	\$402,793,216	1.0808	1.1022	1.98%	-3.03%	-0.35%	-\$1,409,776	1.1022	0.9697	-0.36%	-\$1,450,056	-\$1,409,776	-0.35%	Imp
210005	Frederick	\$288,140,344	1.0140	1.0204	0.64%	-3.03%	-0.28%	-\$743,965	1.0204	0.9697	-0.14%	-\$400,596	-\$400,596	-0.14%	Att
210008	Mercy	\$249,515,476	0.9586	0.9373	-2.22%	-3.03%	-0.06%	-\$149,709	0.9373	0.9697	0.09%	\$224,564	\$224,564	0.09%	Att
210009	Johns Hopkins	\$1,984,717,053	1.1240	1.1016	-1.99%	-3.03%	-0.07%	-\$1,389,302	1.1016	0.9697	-0.36%	-\$7,144,981	-\$1,389,302	-0.07%	Imp
210011	Ascension Saint Agnes	\$269,943,037	0.9047	0.9241	2.15%	-3.03%	-0.36%	-\$971,795	0.9241	0.9697	0.12%	\$323,932	\$323,932	0.12%	Att
210012	Sinai	\$578,915,177	1.1877	1.1061	-6.87%	-3.03%	0.27%	\$1,557,671	1.1061	0.9697	-0.37%	-\$2,134,586	\$1,557,671	0.27%	Imp
210015	MedStar Fr Square	\$437,038,002	0.9259	0.9571	3.36%	-3.03%	-0.44%	-\$1,922,967	0.9571	0.9697	0.03%	\$131,111	\$131,111	0.03%	Att
210016	Adventist White Oak	\$306,648,357	1.1923	1.1183	-6.21%	-3.03%	0.22%	\$674,626	1.1183	0.9697	-0.40%	-\$1,226,593	\$674,626	0.22%	Imp
210017	Garrett	\$30,285,668	0.7778	0.7708	-0.91%	-3.03%	-0.15%	-\$45,429	0.7708	0.9697	0.50%	\$151,428	\$151,428	0.50%	Att
210018	MedStar Montgomery	\$110,817,149	0.8793	0.8266	-5.98%	-3.03%	0.21%	\$232,716	0.8266	0.9697	0.39%	\$432,187	\$432,187	0.39%	Att
210019	Peninsula	\$394,776,979	0.8907	0.8415	-5.53%	-3.03%	0.17%	\$671,121	0.8415	0.9697	0.35%	\$1,381,719	\$1,381,719	0.35%	Att
210022	Suburban	\$275,339,890	0.9379	0.9059	-3.40%	-3.03%	0.03%	\$82,602	0.9059	0.9697	0.17%	\$488,078	\$488,078	0.17%	Att
210023	Anne Arundel	\$461,250,402	0.9498	0.9625	1.34%	-3.03%	-0.30%	-\$1,383,751	0.9625	0.9697	0.02%	\$92,250	\$92,250	0.02%	Att
210024	MedStar UnionMem	\$316,870,786	1.0143	0.9461	-6.72%	-3.03%	0.26%	\$823,864	0.9461	0.9697	0.06%	\$190,122	\$823,864	0.26%	Imp
210027	Western Maryland	\$202,494,635	0.9413	0.9838	4.51%	-3.03%	-0.50%	-\$1,012,473	0.9838	0.9697	-0.04%	-\$80,998	-\$80,998	-0.04%	Att
210028	MedStar St. Mary's	\$98,519,520	0.8929	0.8843	-0.96%	-3.03%	-0.14%	-\$137,927	0.8843	0.9697	0.23%	\$226,595	\$226,595	0.23%	Att
210029	JH Bayview	\$522,055,692	1.1503	1.1403	-0.87%	-3.03%	-0.15%	-\$783,083	1.1403	0.9697	-0.46%	-\$2,401,466	-\$783,083	-0.15%	Imp
210032	ChristianaCare, Union	\$114,302,009	0.8950	0.8949	0.00%	-3.03%	-0.21%	-\$240,034	0.8949	0.9697	0.20%	\$228,604	\$228,604	0.20%	Att
210033	Carroll	\$178,074,349	0.9155	0.9398	2.65%	-3.03%	-0.40%	-\$712,297	0.9398	0.9697	0.08%	\$142,459	\$142,459	0.08%	Att
210034	MedStar Harbor	\$147,837,218	0.8967	0.8596	-4.14%	-3.03%	0.08%	\$118,270	0.8596	0.9697	0.30%	\$443,512	\$443,512	0.30%	Att
210035	UM-Charles Regional	\$109,649,404	0.9984	0.9562	-4.23%	-3.03%	0.08%	\$87,720	0.9562	0.9697	0.04%	\$43,860	\$87,720	0.08%	Imp
210037	UM-Easton	\$162,954,562	0.9575	0.9659	0.87%	-3.03%	-0.27%	-\$439,977	0.9659	0.9697	0.01%	\$16,295	\$16,295	0.01%	Att
210038	UMMC Midtown	\$155,503,757	1.0610	1.1092	4.54%	-3.03%	-0.50%	-\$777,519	1.1092	0.9697	-0.38%	-\$590,914	-\$590,914	-0.38%	Att
210039	Calvert	\$89,452,152	0.7856	0.7827	-0.38%	-3.03%	-0.18%	-\$161,014	0.7827	0.9697	0.50%	\$447,261	\$447,261	0.50%	Att
210040	Northwest	\$185,021,826	1.0818	1.0387	-3.98%	-3.03%	0.07%	\$129,515	1.0387	0.9697	-0.19%	-\$351,541	\$129,515	0.07%	Imp
210043	UM-BWMC	\$337,061,709	0.9319	0.9103	-2.32%	-3.03%	-0.05%	-\$168,531	0.9103	0.9697	0.16%	\$539,299	\$539,299	0.16%	Att
210044	GBMC	\$285,831,225	0.9758	0.9924	1.70%	-3.03%	-0.33%	-\$943,243	0.9924	0.9697	-0.06%	-\$171,499	-\$171,499	-0.06%	Att
210048	Howard County	\$260,887,192	0.9281	0.9103	-1.92%	-3.03%	-0.08%	-\$208,710	0.9103	0.9697	0.16%	\$417,420	\$417,420	0.16%	Att
210049	UM-Upper Chesapeake	\$279,739,543	0.9665	0.9377	-1.97%	-3.03%	-0.07%	-\$195,818	0.9377	0.9697	0.09%	\$251,766	\$251,766	0.09%	Att
210051	Doctors	\$187,925,562	1.0789	0.9972	-7.58%	-3.03%	0.32%	\$601,362	0.9972	0.9697	-0.07%	-\$131,548	\$601,362	0.32%	Imp
210056	MedStar Good Sam	\$196,413,974	0.9834	0.9732	1.02%	-3.03%	-0.28%	-\$549,959	0.9732	0.9697	-0.01%	-\$19,641	-\$19,641	-0.01%	Att
210057	Shady Grove	\$364,335,482	1.1382	1.0777	-5.31%	-3.03%	0.16%	\$682,937	1.0777	0.9697	-0.29%	-\$1,066,573	\$682,937	0.16%	Imp
210060	Ft. Washington	\$39,131,159	1.0396	0.9705	-6.64%	-3.03%	0.25%	\$97,828	0.9705	0.9697	0.00%	\$0	\$97,828	0.25%	Imp
210061	Atlantic General	\$49,382,101	0.8298	0.8091	-2.49%	-3.03%	-0.04%	-\$19,753	0.8091	0.9697	0.44%	\$217,281	\$217,281	0.44%	Att
210062	MedStar Southern MD	\$204,927,843	0.9011	0.8421	-6.54%	-3.03%	0.24%	\$491,827	0.8421	0.9697	0.35%	\$717,247	\$717,247	0.35%	Att
210063	UM-St. Joe	\$310,535,107	0.8487	0.8660	0.86%	-3.03%	-0.27%	-\$838,445	0.8660	0.9697	0.31%	\$962,659	\$962,659	0.31%	Att
210065	HC-Germantown	\$108,347,654	1.0263	1.0635	3.62%	-3.03%	-0.46%	-\$489,199	1.0635	0.9697	-0.26%	-\$276,504	-\$276,504	-0.26%	Att
STATEWIDE		\$12,379,325,935						-\$18,594,307				-\$13,011,986	\$3,624,728	0.03%	
Penalty								-\$24,746,366				-\$21,707,456	-\$9,392,283	-0.08%	
Reward								\$6,152,059				\$8,695,470	\$13,017,011	0.11%	





maryland  
**health services**  
cost review commission

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# Global Budget (GBR) Carve-outs: Commission Draft Recommendation

June 2026

# Agenda

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- Executive Summary
- Staff definition of highly specialized care eligible for carve-outs using MS-DRGs
  - Scenario 2: Less restrictive approach
  - Carve-out list validations and refinements
  - Statewide hospital Carve-out impact
- Carve-out funding and implementation
- Monitoring and updating the list of Carve-out services
- Staff draft recommendations

- **Key Discussion Topics**

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- Analysis approach
- Proposed DRG list
- Alignment on the proposed carve-out amount
- Implementation approach

# Executive Summary: Updated DRG-Based Analysis

Scenario <sup>1</sup>	Total carve out charges	% of In-state revenue	# of MS-DRGs Flagged
Less restrictive	\$1.9B	9.4%	66

## Priorities and Approach

- Protect access to care for rare life-threatening conditions in a way that is manageable for hospitals while considering affordability for the system as a whole
  - The staff proposed DRG list would result in **\$1.1B** carved out of **AMC** GBRs, **\$541M** carved out associated with **MIEMSS specialty designations**, and **\$280M** carved out at **other hospitals**
- Carve out only services that are highly specialized, highly acute and unpredictable
  - Incorporated multiple indicators, including **CMI, AMC and specialty hospital case share, and MIEMSS-designated specialties**, within an **MS-DRG MDC-guided framework**, with clinical refinements where needed to better isolate highly specialized care
- The **HSCRC developed list** is set to be **effective July 1, 2026**; staff will **align with a CMMI list on January 1, 2028**
- **Baseline volumes** for carve-out eligible services will be established **using CY 2025 performance inflated to FY 2027** and volumes will be monitored and updated as needed
- Use the **15 percent AHEAD carve-out cap as the monitoring guardrail** triggering updates and refinements to the carve-out list

Notes: 1 - The less restrictive scenario includes Quaternary DRGs (DRGs 1-19 and AMC dominant) + Tertiary DRGs (defined as NICU, Burns, Trauma, Oncology and Cardiology) with clinician adjustments

# Stakeholder priorities for defining specialized care and use of the AHEAD carve-out



## Broadening the Scope of Eligible Services

- The current Complexity & Innovation policy limits funding eligibility to AMCs only
- Stakeholders noted that expanding eligibility beyond AMCs to include certain tertiary and quaternary services performed at non-AMCs could better align with AHEAD goals



## Simplifying Policy for Transparency and Stability

- Stakeholders expressed support for a simpler carve-out approach to improve stability and enable modeling
- Stakeholders agree that complex care is difficult to manage under fixed budgets and should remain a priority for carve-outs under clear, stable definitions
- Several stakeholders recommended using a DRG approach and/or the Sg2 tertiary/quaternary DRG list to define eligible services



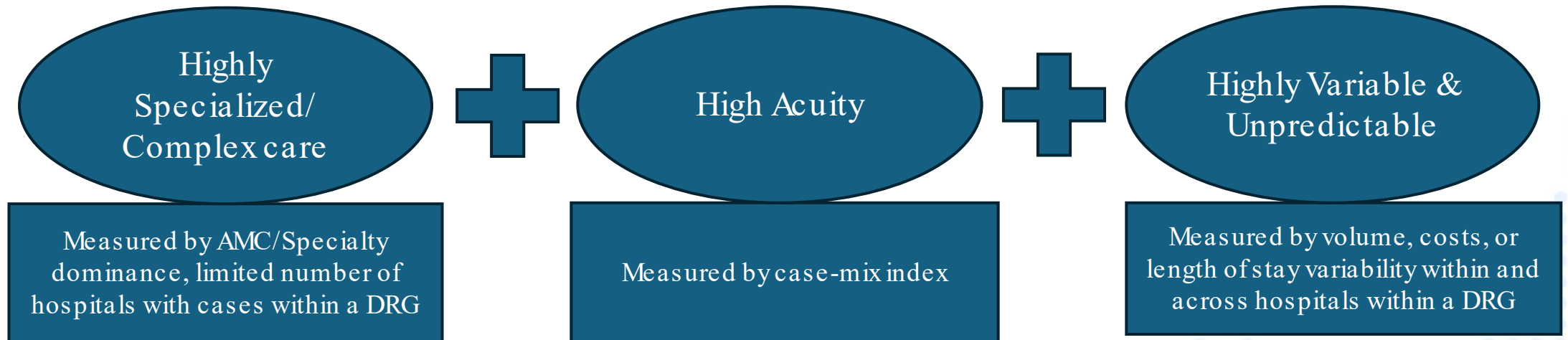
## Use of the AHEAD 15% GBR Carve-Out

- The AHEAD Model provides the opportunity to increase GBR carve-outs to 15% of revenue
- The expanded 15% carve-out allowance under AHEAD should be used deliberately, prioritizing services that materially improve AHEAD program alignment
- *It is important to note that the full 15% cannot be carved out, as this threshold also includes other carve-outs (e.g., high-cost drugs) and accommodates growth and future innovative carve-out eligible services*

# Defining highly specialized care for GBR carve-out consideration

**Highly Specialized Care:** Highly specialized and complex care refers to **advanced tertiary and quaternary services for rare or life-threatening conditions delivered at the highest levels of care**, defined by staff specifically as, **quaternary and tertiary** care at AMCs (i.e. a limited number of hospitals with advanced resources for treating highly complex cases) and **tertiary** care at MIEMSS-designated and NCI-designated specialty centers (i.e., a limited number of hospitals with specialized programs and resources for treating highly complex cases such as trauma, NICU, cardiac)

Cases considered for carve-out under this policy must meet all three criteria



# Defining highly specialized care for GBR carve-out consideration Cont....

## *High acuity ≠ highly specialized*



### Highly acute AND specialized

Services within areas such as **burn care**, **NICU**, and **trauma** can be highly acute and highly specialized, often delivered at a limited number of designated centers



### Highly acute but NOT specialized

In contrast, **some cardiac services** can be highly acute but broadly distributed (~24 hospitals), indicating greater volume dispersion; they are relatively accessible rather than specialized

**Highly acute and specialized services** prioritized for the carve-out **should also be unpredictable or inconsistent** in terms of cost, volume, length of stay, or care pathway. These types of cases are not ideal for a population-based methodology due to their variable nature and therefore would be identified as carve-out eligible

# Updated DRG-Based Approach to Identify Highly specialized Care

## MS-DRG Based Analysis Approach

1. Carve out Pre-MDC DRGs (1-19) as quaternary care
2. Apply AMC cell dominance and CMI thresholds to identify additional quaternary DRGs
3. Define specialty care using MIEMSS designations:
  - Cardiac, Stroke, NICU, Burns, Trauma, and Oncology (NCI designation)
4. Apply AMC + specialty hospital cell dominance and CMI thresholds to identify tertiary DRGs
5. Validate and refine DRG list through:
  - Clinical review
  - Assessment of completeness of DRG families (Complication or Comorbidity (CC)/Major complication or comorbidity (MCC) hierarchy)
  - Review DRG consistency between FY2023 – FY2025
  - Comparison to CMMI, Sg2, and other stakeholder provided lists
- Ultimately, it is the list that matters and not the methodology so seeking alignment on a list from CMMI

# Recommended Carve-out Thresholds – Less Restrictive Scenario

The less restrictive scenario includes the same categories as the more restrictive scenario on the previous slide, along with cardiology and oncology DRGs with clinician adjustments.

<b>Total carve out charges</b>	<b>% of In-state revenue*</b>	<b>Number of DRGs</b>
<b>\$ 1.9B</b>	<b>9.4%</b>	<b>66</b>
<b>% AMC Contribution to Carve out charges</b>	<b>% Specialty Hosp Contribution to Carve out charges</b>	<b>% Other Hosp Contribution to Carve out charges</b>
<b>58%</b>	<b>28%</b>	<b>14%</b>

Categories	Quaternary		Tertiary					
	Pre-MDC (DRGs 1-19)	AMC Dominance	Cardiac	Stroke	Burn	Trauma	NICU	Oncology
<b>Cell Dominance</b>	-	<b>50%</b>	<b>90%</b>	<b>90%</b>	<b>90%</b>	<b>50%</b>	<b>60%</b>	<b>60%</b>
<b>CMI</b>	-	<b>2.5</b>	<b>2.5</b>	<b>1.5</b>	<b>1.5</b>	<b>2.5</b>	<b>1.5</b>	<b>1.5</b>
<b>Charges in \$M</b>	<b>\$654.5</b>	<b>\$96.5</b>	<b>\$568.1</b>	-	<b>\$15.4</b>	<b>\$319.3</b>	<b>\$240.5</b>	<b>\$66.5</b>

# The baseline DRG list was refined through multiple validation approaches and comparisons

1. **Threshold calibration:** Thresholds vary across categories for carve-outs to better capture highly specialized services based on DRG distributions and cost variations associated with different services including areas like NICU that may not meet higher cell-dominance thresholds
2. **Exclusion review:** Reviewed and removed from list few select medical DRGs for rehab and psych which met the carve-out services thresholds
3. **Year-over-year validation:** The majority of DRGs identified as highly specialized remained consistent from FY 2023 to FY 2025, with fewer than 10 DRGs newly classified as highly specialized under the same criteria in FY 2025
4. **CC/MCC hierarchy validation:** Reviewed “With Complication or Comorbidity” (CC) and “With Major Complication or Comorbidity” (MCC) DRG hierarchy logic to ensure consistency within DRG families, specifically (1) manually adding to the list, the MCC DRG if the CC variant made the list, but the MCC did not; and (2) No change to instances where the MCC made the list and the CC did not
  - Change from the previous iteration to exclude both if the lesser severity DRG met the list while the major DRG did not
5. **Comparison to CMMI and other stakeholder developed lists:** There was significant overlap between the staff proposed DRG list, the CMMI lists and other stakeholder-developed lists
  - 80 percent overlap between DRGs identified on our lists and CMMI’s initial list. NICU represents a significant portion of revenue gap
6. **Clinical validation:** The clinical team found the approach to be directionally sound and analytically rigorous. Discussions also refined which cardiac DRGs should be considered highly specialized and deemed all spinal fusion DRGs as “standard of care” and not highly specialized

# Clinical Validation and Refinement

## DRGs manually removed from the Carve-outs lists

The clinical team flagged the following DRGs for removal from carve-out eligible volumes given the high level of volume dispersion across the AMC and specialty hospitals. They believed that while these cases are highly acute, they are deemed as “standard of care” rather than highly specialized

226	Cardiac Defibrillator Implant without Cardiac Catheterization with MCC
227	Cardiac Defibrillator Implant without Cardiac Catheterization without MCC
245	AICD Generator Procedures
258	Cardiac Pacemaker Device Replacement with MCC
275	Cardiac Defibrillator Implant with Cardiac Catheterization and MCC
276	Cardiac Defibrillator Implant with MCC or Carotid Sinus Neurostimulator
277	Cardiac Defibrillator Implant without MCC
456	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with MCC
457	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with CC
458	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions without CC/MCC
459	Spinal Fusion Except Cervical with MCC
471	Cervical Spinal Fusion with MCC

*Cardiac valve DRGs previously removed from the carve-out list have been reinstated but will be monitored on an annual basis*

## DRGs flagged for further investigation

4	Tracheostomy with MV>96 Hours or Principal Diagnosis Except Face, Mouth and Neck without Major O.R. Procedures
492	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with MCC
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC
653	Major Bladder Procedures with MCC
789	Neonates, Died or Transferred to Another Acute Care Facility
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate

# 100% VCF Funding and FY 2027 Implementation

## **100 Percent VCF Funding and Removed from Other Volume Policies**

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- All in-state cases with DRG assignments that exist on the carve out list, regardless of whether they are seen at an AMC, specialty or community hospital will be funded at 100% VCF
  - As such, hospitals are responsible for all changing volumes associated with these cases should they either grow or decline
  - Funding of all other volumes not on the carve-outs list will maintain the respective medical and surgical service line VCFs
- The carve-out policy will replace the current Complexity and Innovation policy; therefore, all prospective funding related to that policy in the update factor will be discounted upon approval of a formal carve-out policy
- All in-state cases with DRG assignments on the carve-out list will be removed from all eligible volume policies including but not limited to: Market Shift Adjustment, Demographic Adjustment, Surge Funding, Deregulation, and Repatriation/Expatriation
  - Carve-out volumes will continue to be assessed in the various quality pay-for-performance and PAU Redistribution Policies

## **CY 2025 Base Implemented in FY 2027**

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- The Commission is committed to carving out eligible volumes for Maryland hospitals starting in FY 2027
  - Provision for additions to the proposed carve-out list in January 2028, once a CMMI final list is released
- Baseline volumes for carve-out eligible services will use CY 2025 performance inflated to FY 2027
  - Due to the volatility of these services, base volumes for small rural hospitals will be assessed to reflect true experience using a three-year average

# Monitoring and Updating the List of Carve-Out Services

- **CMMI List:** Staff will work with CMMI on the carve out list under their Hospital Global Budgets and where possible update the Maryland list to match the final CMMI list in CY 2028
- **Adding DRGs:** Staff will annually review DRG updates to consider if new DRGs should be added to the carve out list
- **Removing DRGs:** Staff will annually review utilization of DRGs on the carve-out lists and consider removing DRGs which have diffused across a majority of hospitals and that may no longer qualify as highly specialized
  - To avoid locking into the global budget utilization patterns that do not reflect the end state of diffusion, charges will be added back to the global budget for dropped DRGs based on recent utilization levels once diffusion is believed to be complete
- **Program Monitoring & AHEAD Carve-out Limit:** Staff will monitor overall utilization across carved out DRGs to ensure compliance with the overall goal of the carve-out policy, the HSCRCs regulatory mandate and the AHEAD model
  - Staff will consider changes to the carve-out lists to ensure the most appropriate use of the carve out should unintended issues be noted or the State risk maxing out the 15 percent cap

*Any changes contemplated under the bullets above will be shared with the relevant HSCRC workgroups. Material changes under any of these provisions will be subject to Commission approval*

# Staff Draft Recommendations

1. Staff propose the adoption of the less restrictive list effective July 1, 2026, which carves out approximately 9.4 percent of statewide revenue associated with highly specialized care from population-based methodologies
  - Proposed carve-out list prioritizes highly specialized tertiary and quaternary care performed at AMCs (58 percent), with expansions to include certain tertiary services also performed at non-AMCs (42 percent)
  - The list could be updated effective January 1, 2028, based on desired alignment with a final CMMI list
2. Staff propose the use of CY 2025 charges, inflated to FY 2027, as the baseline for carve-out eligible volume which would be removed from global budgets. The baseline for lower volume hospitals should be based on a three-year average
3. Staff propose that all volumes eligible for carve-outs under this policy are funded at 100 percent variable costs and hospitals are held 100 percent liable for volatility
4. All prospective adjustments in FY 2027 rates relevant to the current Complexity and Innovation Policy will be reversed upon a Carve-out Policy approval, retrospective adjustments for FY 2025 and FY 2026 will be made
5. Staff propose the removal of all carve-out cases from all other volume methodologies including the Market Shift, Demographic Adjustment, Surge Funding, Deregulation, and Repatriation/Expatriation
  - Continue including carve-out eligible cases in the quality pay-for-performance and PAU Redistribution assessments
6. Staff propose to review the list annually (1) for potential additions and subtractions and (2) to understand the impact of the policy. Material changes will be brought to the Commission for approval
7. Volumes eligible under the existing Outpatient Cosmetic Surgery program will also be carved out effective July 1, 2027

# Appendix

# Less restrictive DRG details after Clinical Edits


# Pre-MDC DRGs (DRG 1-19)

Highly Specialized Flagged DRGs

MS DRG	MS DRG Descriptions	Discharges			Average IP Weight	Charges
		Statewide	AMC	% AMC of Statewide cases	Statewide	Statewide
1	Heart Transplant or Implant of Heart Assist System with MCC	122	118	97%	9.7	\$88,012,894
2	Heart Transplant or Implant of Heart Assist System without MCC	4	4	100%	13.1	547,895
3	ECMO or Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. Procedures	903	552	61%	11.1	312,805,214
4	Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck without Major O.R. Procedures	621	124	20%	8.3	118,512,660
5	Liver Transplant with MCC or Intestinal Transplant	124	124	100%	10.5	37,656,840
6	Liver Transplant without MCC	32	32	100%	7.0	6,139,348
7	Lung Transplant	20	20	100%	14.8	9,442,734
8	Simultaneous Pancreas and Kidney Transplant	7	7	100%	9.3	1,907,059
10	Pancreas Transplant	0	0	0%	0.0	0
11	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy with MCC	95	73	77%	2.9	12,204,681
12	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy with CC	109	83	76%	2.1	13,160,414
13	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy without CC/MCC	12	8	67%	2.0	703,756
14	Allogeneic Bone Marrow Transplant	84	84	100%	6.4	15,202,051
16	Autologous Bone Marrow Transplant with CC/MCC	80	80	100%	3.0	6,080,017
17	Autologous Bone Marrow Transplant without CC/MCC	0	0	0%	0.0	0
18	Chimeric Antigen Receptor (CAR) T-Cell and Other Immunotherapies	65	65	100%	16.3	31,652,312
19	Simultaneous Pancreas and Kidney Transplant with Hemodialysis	2	2	100%	8.9	456,346

Highly Specialized DRG Count - 17

# AMC Cell-dominance analysis ( $\geq 50\%$ Cell Dominance, $\geq 2.5$ CMI)

 Highly Specialized Flagged DRGs

CMS DRGs	Description	Discharges			Average IP Weight	Charges
		Statewide	AMC	AMC %	Statewide	Statewide
652	Kidney Transplant	153	153	100%	5.3	\$22,242,033
650	Kidney Transplant with Hemodialysis with MCC	84	84	100%	5.7	14,966,109
651	Kidney Transplant with Hemodialysis without MCC	32	32	100%	5.4	4,708,446
143	Other Ear, Nose, Mouth and Throat O.R. Procedures with MCC	46	34	74%	2.7	3,826,601
456	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with MCC	83	54	65%	5.1	12,846,212
31	Ventricular Shunt Procedures with MCC	75	46	61%	2.9	5,940,358
458	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions without CC/MCC	126	75	60%	3.1	9,793,924
405	Pancreas, Liver and Shunt Procedures with MCC	195	107	55%	3.4	18,752,485
20	Intracranial Vascular Procedures with Principal Diagnosis Hemorrhage with MCC	125	67	54%	3.7	21,227,438
457	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with CC	254	135	53%	3.8	27,342,460
653	Major Bladder Procedures with MCC	60	30	50%	3.3	4,855,325

Highly Specialized DRG Count - 08

# Cardiac DRGs (>=90% Cell Dominance, >=2.5 CMI)

Highly Specialized Flagged DRGs

DRG	Description	Discharge				Average IP Weight	Charges
		Statewide	AMC	Specialty	(AMC + Specialty) % of Statewide cases	Specialty	Statewide
236	Coronary Bypass without Cardiac Catheterization without MCC	917	293	624	100%	3.0	\$63,484,239
270	Other Major Cardiovascular Procedures with MCC	927	209	642	92%	2.7	64,964,310
234	Coronary Bypass with Cardiac Catheterization or Open Ablation without MCC	449	43	406	100%	3.3	35,635,919
233	Coronary Bypass with Cardiac Catheterization or Open Ablation with MCC	268	45	223	100%	4.2	28,492,226
235	Coronary Bypass without Cardiac Catheterization with MCC	308	136	172	100%	3.9	31,135,104
275	Cardiac Defibrillator Implant with Cardiac Catheterization and MCC	166	30	136	100%	4.2	15,720,874
276	Cardiac Defibrillator Implant with MCC or Carotid Sinus Neurostimulator	141	36	104	99%	3.6	12,663,391
228	Other Cardiothoracic Procedures with MCC	149	55	94	100%	3.3	13,821,261
277	Cardiac Defibrillator Implant without MCC	142	42	99	99%	2.9	8,488,529
268	Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC	79	36	36	91%	4.5	9,426,567
231	Coronary Bypass with PTCA with MCC	32	12	20	100%	5.0	5,004,091
212	Concomitant Aortic and Mitral Valve Procedures	19	5	14	100%	4.3	2,792,576
232	Coronary Bypass with PTCA without MCC	24	6	18	100%	3.5	2,340,321
215	Other Heart Assist System Implant	23	13	10	100%	5.7	4,150,635
245	AICD Generator Procedures	22	7	15	100%	2.9	1,745,062
258	Cardiac Pacemaker Device Replacement with MCC	13	4	9	100%	2.7	473,386
216	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC	155	57	98	100%	5.1	25,276,064
217	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with CC	84	25	59	100%	3.9	9,004,774
218	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization w/o CC/MCC	2	0	2	100%	3.3	154,696
219	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with MCC	450	274	176	100%	5.1	69,477,906
266	Endovascular Cardiac Valve Replacement and Supplement Procedures with MCC	413	194	219	100%	4.5	47,062,198
267	Endovascular Cardiac Valve Replacement and Supplement Procedures without MCC	1,077	380	697	100%	3.6	81,217,011
319	Other Endovascular Cardiac Valve Procedures with MCC	13	9	4	100%	2.8	989,490
220	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with CC	672	376	295	100%	3.6	68,725,255
221	Cardiac Valve and Other Major Cardiothoracic Procedures w/o Cardiac Catheterization w/o CC/MCC	62	30	31	98%	3.0	4,918,472
263	Vein Ligation and Stripping	12	4	7	92%	2.5	732,230

Highly Specialized DRG Count - 20

# Stroke DRGs (>=90% Cell Dominance, >=1.5 CMI)

Highly Specialized Flagged DRGs

DRG	Description	Discharges				Average IP Weight	Charges
		Statewide	AMC	Specialty	(AMC + Specialty) % of Statewide cases	Specialty	Statewide
61	Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent with MCC	226	14	77	40%	1.4	\$9,659,497
62	Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent with CC	528	22	156	34%	0.8	15,745,924
63	Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent without CC/MCC	151	1	53	36%	0.7	3,999,071
64	Intracranial Hemorrhage or Cerebral Infarction with MCC	3,268	394	832	38%	1.5	97,569,387
65	Intracranial Hemorrhage or Cerebral Infarction with CC or TPA in 24 Hours	4,353	325	810	26%	0.9	72,923,950
66	Intracranial Hemorrhage or Cerebral Infarction without CC/MCC	1,049	69	171	23%	0.7	11,911,230
69	Transient Ischemia without Thrombolytic	975	53	142	20%	0.6	12,453,410

Highly Specialized DRG Count - 00

# Burns DRGs ( $\geq 90\%$ Cell Dominance, $\geq 1.5$ CMI)

Highly Specialized Flagged DRGs

DRG	Description	Discharges				Average IP Weight	Charges
		Statewide	AMC	Specialty	(AMC + Specialty) % of Statewide cases	Specialty	Statewide
927	Extensive Burns or Full Thickness Burns with MV >96 Hours with Skin Graft	12	4	8	100%	12.4	\$6,126,123
928	Full Thickness Burn with Skin Graft or Inhalation Injury with CC/MCC	67	8	58	99%	3.7	8,040,976
929	Full Thickness Burn with Skin Graft or Inhalation Injury without CC/MCC	33	12	21	100%	2.2	1,240,439
933	Extensive Burns or Full Thickness Burns with MV >96 Hours without Skin Graft	2	0	2	100%	1.2	111,774
934	Full Thickness Burn without Skin Graft or Inhalation Injury	61	18	34	85%	0.6	1,255,444
935	Non-Extensive Burns	179	40	123	91%	1.2	5,517,557

Highly Specialized DRG Count - 03

# NICU DRGs ( $\geq 60\%$ Cell Dominance, $\geq 1.5$ CMI)

Highly Specialized Flagged DRGs

DRG	Description	Discharges				Average IP Weight	Charges
		Statewide	AMC	Specialty	(AMC + Specialty) % of Statewide cases	Specialty	Statewide
789	Neonates, Died or Transferred to Another Acute Care Facility	1,341	353	529	66%	3.5	\$84,256,600
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate	2,051	313	1,515	89%	3.1	156,232,136
791	Prematurity with Major Problems	1,307	239	834	82%	1.2	37,698,053
792	Prematurity without Major Problems	2,722	235	1,727	72%	0.3	20,935,568
793	Full Term Neonate with Major Problems	3,611	580	2,232	78%	0.5	44,556,448

Highly Specialized DRG Count - 02


# Trauma DRGs (>=50% Cell Dominance, >=2.5 CMI)

 Highly Specialized Flagged DRGs

DRG	Description	Discharges				Average IP Weight	Charges
		Statewide	AMC	Specialty	(AMC + Specialty) % of Statewide	Specialty	Statewide
957	Other O.R. Procedures for Multiple Significant Trauma with MCC	342	219	122	100%	4.3	\$43,615,134
958	Other O.R. Procedures for Multiple Significant Trauma with CC	274	152	115	97%	2.5	16,970,812
955	Craniotomy for Multiple Significant Trauma	68	38	26	94%	4.9	8,561,929
140	Major Head and Neck Procedures with MCC	44	33	8	93%	2.9	3,594,747
956	Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma	377	157	142	79%	2.6	33,712,902
	Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator	604	273	185	76%	4.2	59,624,429
25	Craniotomy and Endovascular Intracranial Procedures with MCC	1,323	639	313	72%	3.2	105,164,118
29	Spinal Procedures with CC or Spinal Neurostimulators	204	96	43	68%	2.6	12,425,448
28	Spinal Procedures with MCC	120	55	19	62%	3.5	11,482,284
492	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with MCC	280	77	93	61%	2.7	16,964,481
471	Cervical Spinal Fusion with MCC	147	43	44	59%	3.3	11,788,344
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC	131	40	31	54%	2.7	7,202,700
141	Major Head and Neck Procedures with CC	188	144	25	90%	2.4	9,058,256
959	Other O.R. Procedures for Multiple Significant Trauma without CC/MCC	17	7	8	88%	2.3	566,279
963	Other Multiple Significant Trauma with MCC	157	62	73	86%	1.5	6,370,485
26	Craniotomy and Endovascular Intracranial Procedures with CC	576	305	99	70%	2.1	34,451,183
511	Shoulder, Elbow or Forearm Procedures, Except Major Joint Procedures with CC	125	39	43	66%	1.6	4,292,220
510	Shoulder, Elbow or Forearm Procedures, Except Major Joint Procedures with MCC	27	5	11	59%	2.0	1,245,687
493	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with CC	914	260	265	57%	1.8	38,777,854
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures with CC	380	118	94	56%	1.6	13,760,071
	Wound Debridement and Skin Graft Except Hand for Musculoskeletal and Connective	382	115	98	56%	2.0	21,344,469
464	Tissue Disorders with CC						
494	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur without CC/MCC	549	139	143	51%	1.6	17,725,166
472	Cervical Spinal Fusion with CC	730	210	158	50%	2.2	37,219,260

Highly Specialized DRG Count - 11

# Oncology DRGs ( $\geq 60\%$ Cell Dominance, $\geq 1.5$ CMI)

 Highly Specialized Flagged DRGs

MS DRG	MS DRG Descriptions	Discharges			Average IP Weight	Charges
		Statewide	AMC	% AMC of Statewide cases	Statewide	Statewide
837	Chemotherapy with Acute Leukemia as Secondary Diagnosis or with High Dose Chemotherapy Agent with MCC	113	105	93%	3.2	\$10,991,866
838	Chemotherapy with Acute Leukemia as Secondary Diagnosis with CC or HighDose Chemotherapy Agent	157	142	90%	2.0	8,451,626
846	Chemotherapy without Acute Leukemia as Secondary Diagnosis with MCC	240	197	82%	1.6	11,221,493
834	Acute Leukemia with MCC	249	188	76%	3.4	28,512,456
829	Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other Procedures with CC/MCC	116	72	62%	2.0	7,320,752
835	Acute Leukemia with CC	154	87	57%	2.2	7,891,705
821	Lymphoma and Leukemia with Major O.R. Procedures with CC	36	19	53%	2.1	1,815,509

Highly Specialized DRG Count - 05

# MIEMSS Specialty Hospital Designations

HOSPID	Hospital Name	Cardiac	Stroke	NICU	Burns	Trauma
210029	Bayview Medical Center (JHM)	Y	Y	Y	Y	Y
210003	Capital Region Medical Center (UM)	Y		Y		Y
210012	Sinai Hospital of Baltimore (LifeBridge)	Y	Y	Y		Y
210022	Suburban Hospital (JHM)	Y	Y			Y
210001	Meritus Medical Center	Y				Y
210019	Peninsula Regional Medical Center (TidalHealth)	Y				Y
210027	Western Maryland (UPMC)	Y				Y
210024	Union Memorial Hospital (MedStar)	Y				
210023	Anne Arundel Medical Center (Luminis)	Y		Y		
210005	Frederick Health Hospital	Y		Y		
210044	Greater Baltimore Medical Center			Y		
210004	Holy Cross Hospital - Silver Spring	Y		Y		
210048	Howard County Medical Center (JHM)	Y		Y		
210008	Mercy Medical Center			Y		
210011	Saint Agnes Health (Ascension)	Y		Y		
210063	Saint Joseph Medical Center (UM)	Y		Y		
210057	Shady Grove Medical Center (Adventist HealthCare)	Y	Y	Y		
210015	Franklin Square Medical Center (MedStar)	Y	Y	Y		
210043	Baltimore Washington Medical Center (UM)	Y				
210033	Carroll Hospital (LifeBridge)	Y				
210037	Shore Medical Center at Easton (UM)	Y				
210062	Southern Maryland Medical Center (MedStar)	Y				
210049	Upper Chesapeake Medical Center (UM)	Y				
210016	White Oak Medical Center (Adventist HealthCare)	Y				

# FY 2025 Hospital-specific Carve-out Magnitude

HOSPID	HOSPITALNAME	Carve-out Services as a percent of Total In-state Charges
218992	UMMS-Shock Trauma	44.4%
210002	UMMS- UMMC	29.5%
210009	JHH- Johns Hopkins	17.7%
210063	UMMS- St. Joe	16.4%
210003	UMMS- Capital Region	15.4%
210024	MedStar- Union Mem	15.2%
210022	JHH- Suburban	10.4%
210004	Trinity - Holy Cross	10.1%
210016	Adventist- White Oak	9.6%
210029	JHH- Bayview	9.3%
210019	Tidal- Peninsula	7.0%
210012	Lifebridge- Sinai	6.2%
210023	Luminis- Anne Arundel	6.1%
210015	MedStar- Franklin Square	5.9%
210027	Western Maryland	5.6%
210057	Adventist- Shady Grove	5.3%
210011	Saint Agnes	4.1%
210044	GBMC	3.9%
210043	UMMS- BWMC	3.3%
210008	Mercy	3.2%
210060	Adventist-Ft. Washington	2.6%
210048	JHH- Howard County	2.5%
210062	MedStar- Southern MD	2.0%
210049	UMMS-Upper Chesapeake	1.9%
210005	Frederick	1.9%
210001	Meritus	1.8%
210065	Trinity - Holy Cross Germantown	1.7%
210038	UMMS- Midtown	1.6%
210051	Luminis- Doctors	1.5%
210056	MedStar- Good Sam	1.2%
210032	ChristianaCare, Union	1.0%
210037	UMMS- Easton	0.9%
210035	UMMS- Charles	0.9%
210033	Lifebridge- Carroll	0.9%
210034	MedStar- Harbor	0.7%
210040	Lifebridge- Northwest	0.5%
210028	MedStar- St. Mary's	0.5%
210039	Calvert	0.4%
210018	MedStar- Montgomery	0.3%
210058	UMMS- UMROI	0.1%
210017	Garrett	0.1%

Based on the Staff proposed list of Carve-out eligible DRGs using FY 2025 data

- 44 percent of revenues could be carved out of University of Maryland Shock Trauma
  - The nations first and only integrated trauma hospital known for treating the State's most critically sick and severely injured patients
- The State's Academic Medical Centers, University of Maryland Medical Center (UMMS) and Johns Hopkins Hospital (JHH) could have about 30 percent and 18 percent of revenues carved of global budgets, respectively
- 15 specialty hospitals could have carve-out revenue ranging from 16 percent at UM St. Joseph to 4 percent at GBMC
- At most 3 percent of revenues could be carved out from 19 acute care hospitals
- Free-Standing Medical Facilities (FMFs) and Free-standing Emergency Centers (FMEs) will have no portion of their revenues carved out

Carve-outs will be based on CY 2025 data



maryland  
**health services**  
cost review commission

## **Draft Recommendation for Global Budget Carve-outs Under AHEAD**

June 10, 2026

Health Services Cost Review Commission

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This document contains the draft staff recommendations for Global Budget Carve-outs under AHEAD. Please submit comments on this draft to the Commission by Friday, June 19, 2026, via email to [william.henderson@maryland.gov](mailto:william.henderson@maryland.gov) and [prudence.akindo@maryland.gov](mailto:prudence.akindo@maryland.gov)

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## Executive Overview

This draft policy presents a list of services determined by staff as highly specialized care, eligible for carve-out from population-based methodologies per Achieving Healthcare Efficiency through Accountable Design (AHEAD) specifications. This document outlines the staff methodology for determining the list of services based on a five-part criteria which prioritizes quaternary and tertiary care performed at the states' academic medical centers and tertiary services performed at other service specialty designated hospitals in the state. Carve-out volumes will be based on calendar year 2025 (CY 2025) performance inflated to fiscal year 2027 (FY 2027) and removed from the hospital's global budget. Going forward, carved-out volumes will be charged at 100 percent of the current applicable rates (i.e. 100 percent variable cost factor) with hospitals being held 100 percent liable for volume volatility.

## Introduction

In 2014, Maryland transitioned all its acute care hospitals to an All-Payer Global Budget Revenue (GBR) model. Under this model, hospitals operate under fixed revenue caps as opposed to traditional fee-for-service payments. The Maryland All-Payer model focused on improving quality, enhancing health outcomes, and controlling Medicare spending for hospital inpatient and outpatient services. Between 2014 and 2018, hospitals successfully reduced unnecessary readmissions and hospital-acquired conditions while slowing growth in hospital costs per capita. However, the All-Payer Model primarily targeted hospitals and did not fully support coordinated care across the broader health care system.

In 2019, Maryland transitioned to the Total Cost of Care (TCOC) Model. Under the TCOC Model, Maryland was expected to transform care delivery across the health system, improve health and quality of care, and maintain Medicare spending growth below the national rate. The TCOC Model gave Maryland the flexibility to tailor initiatives to the state's unique health care environment and encouraged innovation among providers. It supported investments in population health improvement, care redesign and provided new tools and resources for primary care providers to better manage complex and chronic conditions, helping Marylanders achieve better health. The State achieved significant savings, quality improvements, and care transformation progress under the TCOC Model.

As of January 1, 2026, Maryland transitioned from the Maryland TCOC Model to the national Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model; a voluntary, state-based total cost of care model that allows Maryland to manage healthcare costs and quality and improve the overall health of the state through expanding primary care and strengthening population health.

This policy recommendation will detail the work staff have done with the Volume Workgroup and the methods by which staff and stakeholders concluded on a carve-out list that prioritizes quaternary and tertiary cases performed at academic centers and tertiary services also performed at non-academic hospitals.

## Background

Majority of Maryland hospitals have seen a growth in inpatient case-mix acuity despite declines or stable volumes between fiscal year 2023 (FY 2023) and 2025 (FY 2025). This is an indicator that Maryland has successfully shifted low acuity cases out of the inpatient setting and volumes that tend to remain are appropriate for that setting of care as the patients tend to be sicker and in certain instances require care that is complex and highly specialized.

Given the focus on growth in high acuity and highly specialized care, staff recognize that shielding that care from global budget limitations may be appropriate. While the AHEAD Model includes a requirement that at least 85 percent of in-state, acute care hospital revenue remain under population-based

methodologies that is down from 95% under the Total Cost of Care Model, leaving an opportunity to implement an alternative financing mechanism.

In addition to revising the amount available for exclusion under existing global budgets, Maryland can also propose additional exclusions under the Medicare Hospital Global Budgets that are effective January 1, 2028. As stipulated in section 12(a)(iii) of the State Agreement, “the State may propose additional services to be added to the list of exclusions in the financial specifications for the CMS-Designed Hospital Global Budget Methodology for Medicare FFS. This proposal must include:

1. A definition of additional services to be excluded from the CMS-Designed Hospital Global Budget Methodology for Medicare FFS, as described in this Section 12;
2. A policy explanation for each set of excluded services, which considers various factors such as:
  - . Disproportionate cost growth for certain services driven by factors outside of the control of hospitals;
  - . The innovative nature of certain areas of care, such as high-intensity quaternary and tertiary care;
  - . The statistical reliability of the volume of services provided in a year”<sup>1</sup>

The HSCRC identified (1) revenue associated with high-cost drugs, (2) complex tertiary/quaternary care, and (3) certain low volume surgeries as volumes potentially appropriate for carve-out under AHEAD, given that these services are often unpredictable and often characterized by high volume variability and high-cost. While this recommendation is focused on Maryland’s global budget, the State plans to use the approach developed as a starting point for discussions with CMS.

High-cost outpatient physician-administered drugs were prioritized under the TCOC Model 5 percent carve-out allotment given the volume volatility and high-cost nature of these therapies. The Commission approved use of a quantitative evaluation to identify eligible drugs which are funded at 100 percent of drug costs through the CDS-A policy.<sup>2</sup> Based on this approach, 2.1 percent of total hospital in-state revenue is carved out of hospital GBRs. Not using the entire 5 percent in one year provided enough cushion in the model for growth and future additions of new emerging innovative therapies.

Staff and stakeholders generally support the continuation of high-cost outpatient drug carve-outs identified in the CDS-A Policy under AHEAD albeit with refinements to align with Center for Medicare and Medicaid Innovation’s (CMMI) drug carve-out list. As there is already a carve-out for these drugs that was revised relatively recently, Staff felt that revisions to this policy could wait to be implemented co-incident with the shift to separate Medicare Hospital Global Budgets. However, complex tertiary/quaternary care, some of which was handled under the Complexity and Innovation Policy as well as certain low volume surgeries were flagged by staff and stakeholders as potential areas of opportunity which necessitate new policy development and/or refinements.

## Low volume Surgical Service Lines

Through various statistical analyses done in 2025 to assess the reliability of service lines included in the State’s Market Shift Adjustment policy, staff identified and recommended seven surgical service lines for possible exclusion due to their low volumes.<sup>3</sup> These service lines make up approximately 2.5 percent of

<sup>1</sup>Amended and Restated AHEAD Model Maryland State Agreement

[https://hscrc.maryland.gov/Documents/AHEAD/Amended%20and%20Restated%20AHEAD%20Model%20Maryland%20State%20Agreement\\_vFinal\\_State%20signed\\_CMMI%20Signed\\_vPublic.pdf](https://hscrc.maryland.gov/Documents/AHEAD/Amended%20and%20Restated%20AHEAD%20Model%20Maryland%20State%20Agreement_vFinal_State%20signed_CMMI%20Signed_vPublic.pdf)

<sup>2</sup> Proposed Revisions to Outpatient High-Cost Drug Funding Policy

<https://docs.google.com/document/d/1VZOCwRnIaaPvRQsjJ39rGEpwTffh9wgX/edit>

<sup>3</sup> Final Recommendation for Market Shift Refinement

<https://docs.google.com/document/d/1k8PbDWNNoE594AGLeBfVbLAIMtMXnB6ch/edit>

all in-state revenue and include Endocrinology Surgery, Ear Nose and Throat (ENT) Surgery, Gynecological Surgery, Ophthalmologic Surgery, Thoracic Surgery, Urological Surgery, and Ventilator Support.

While stakeholders generally acknowledged that excluding low-volume surgical service lines could improve market shift reliability, concerns regarding impact on reimbursement, TCOC savings target and access implications led to further evaluations by staff on whether or not to completely carve-out these service lines. Analyses conducted by staff revealed that while these service lines were characterized by low or declining volumes, they also experienced the most growth in acuity levels, hence, fewer but sicker patients seeking care in the most appropriate setting. Hospital-specific evaluations on volume variability for these service lines between FY 2023 and FY 2025 also showed relative stability and as such staff ruled out the decision to carve out these service lines entirely. However, some cases contained within these service lines could be eligible for carve-outs under AHEAD should they meet the expanded quaternary and tertiary care definitions/criteria.<sup>4</sup>

**Figure 1. FY 2023 – 2025 Top Service line Volume and Acuity Growth**

Site	Product Line	FY 23 CMI	FY24 CMI	FY25 CMI	FY23-FY25	FY23-FY25
					CMI Growth	ECMAD Growth
IP	Transplant Surgery	7.33	7.97	8.14	11%	11%
	Ophthalmologic Surg	1.48	1.34	1.54	5%	38%
	Urological Surgery	1.57	1.61	1.64	5%	-3%
	Endocrinology Surgery	1.22	1.23	1.27	4%	-53%
	Gynecological Surg	1.14	1.16	1.18	4%	-11%
	Spinal Surgery	2.31	2.40	2.38	3%	1%
	Vascular Surgery	2.70	2.76	2.78	3%	0%
	Infectious Disease	1.14	1.16	1.17	3%	16%

*Restricted to product lines with Case Mix Growth (CMI) growth rates  $\geq$  the average growth rate of 3% and CMI  $\geq$  1.00 between FY23 and FY24*

## Complex Tertiary and Quaternary Care Services

In CY 2020, Staff developed and the Commission approved the Complexity and Innovation Policy, which determined prospectively through a case-mix acuity and cell dominance approach, highly specialized care. Highly specialized care as defined by the policy includes unique and costly tertiary and/or quaternary services, such as organ transplants, that are typically performed at academic medical centers. To qualify for the policy, hospitals must exhibit a 95 percent cell dominance for procedures related to that service and the case must have a case-mix index of 1.5 or greater.<sup>5</sup> Currently, about 2.7 percent of Maryland in-state, all-payer revenue is funded through the Complexity and Innovation Policy but funding is limited to the States Academic Medical Centers (AMCs).

Staff and Stakeholders believe that with the expanded maximum GBR carve-outs from 5 percent under TCOC to 15 percent under AHEAD, there is opportunity to revise the definitions of “highly specialized care” to capture more services previously defined as population-based though not well suited to fixed global budgets given their high cost, innovation-driven and volume variable nature. The Carve-out Policy will replace the current Complexity and Innovation policy and staff intention is to develop an approach that prioritizes highly complex, innovative quaternary and tertiary care typically occurring at academic medical

<sup>4</sup> See figure 3 on definitions and criteria for identifying tertiary and quaternary care and Appendix 6 with the details

<sup>5</sup> Final Recommendation for a Complexity and Innovation Policy <https://hsrc.maryland.gov/Documents/global-budgets/2023%20Website%20Update%20Files/Final%20Innovation%20Policy%20v3%20%28002%29.pdf>

centers while recognizing that other complex care non-academic hospitals may provide services that are unique and costly and therefore expand the highly specialized care definition to include those hospitals.

## Procedure Code Based Approach

Staff initially sought to leverage the Current Complexity and Innovation Policy framework to define highly specialized care meriting carve-out from population-based methodologies albeit without the nuances associated with the methodology such as cell dominance scenarios, and cost to charge conversions for supplies and drugs. Using the International Classification of Disease (ICD) procedure codes identified under the Current Complexity and Innovation Policy at 95 percent cell dominance and 1.5 CMI thresholds at AMCs, staff isolated procedure codes that meet this criteria statewide to identify eligible cases and carve-out magnitude. Then the cell dominance thresholds were lowered in decrements of 5 percent, stopping at 70 percent while CMI was increased by 0.1 stopping at 2.0 in each scenario, with the goal of increasing carve-out eligible volume statewide to a level that was reasonable while still prioritizing tertiary and quaternary care at the AMCs.<sup>6</sup>

**Figure 2. FY 2025 Statewide Total Charges based on Adjusted Procedure Cell Dominance and CMI Thresholds**

Total charges (in millions \$) (AMC & Non-AMC)	CMI	1.4	1.5	1.6	1.7	1.8	1.9	2.0
Cell Dominance Threshold	95%	\$677	\$670	\$667	\$662	\$656	\$648	\$638
	90%	828	819	815	810	802	793	778
	85%	917	906	903	896	887	874	858
	80%	1,141	1,128	1,123	1,113	1,097	1,078	1,054
	75%	1,308	1,293	1,287	1,274	1,252	1,226	1,199
	70%	1,513	1,495	1,488	1,470	1,443	1,411	1,382

Charges as a % of total in-state revenue (AMC & Non-AMC)	CMI	1.4	1.5	1.6	1.7	1.8	1.9	2.0
Cell Dominance Threshold	95%	3.2%	3.2%	3.1%	3.1%	3.1%	3.1%	3.0%
	90%	3.9%	3.9%	3.8%	3.8%	3.8%	3.7%	3.7%
	85%	4.3%	4.3%	4.2%	4.2%	4.2%	4.1%	4.0%
	80%	5.4%	5.3%	5.3%	5.2%	5.2%	5.1%	5.0%
	75%	6.2%	6.1%	6.1%	6.0%	5.9%	5.8%	5.6%
	70%	7.1%	7.0%	7.0%	6.9%	6.8%	6.6%	6.5%

Staff believes that procedure codes are generally objective and do a better job at isolating specific, highly intensive services; however, they are more frequently subjected to changes making them unstable. Stakeholders argued that the ever-changing nature of procedure codes further complicated the current Complexity and Innovation policy subjecting it to more frequent updates and making it hard for hospitals to predict volumes and therefore they generally expressed a desire to move away from a procedure-based approach in favor of one using Diagnosis Related Groups (DRGs).

## Medicare Severity Diagnosis Related Group (MS-DRG) Based Approach

Stakeholders expressed support for a simpler carve-out approach that has stable, clear definitions and enables modeling. Several recommended using a DRG based approach such as the Sg2's tertiary and quaternary DRG list to define eligible services. CMMI, while indicating a strong preference for using a transparent, non-proprietary approach, also indicated a strong preference towards an MS-DRG based approach for defining carve-out eligible services for reasons of payment simplicity.<sup>7</sup> CMMI also stated that alignment on a list of carve-out services and not a methodology to arrive at an annual carve-out list

<sup>6</sup> See appendix 1: Complex cases at AMC versus Non-AMCs using high end and low-end Procedure-based dominance thresholds

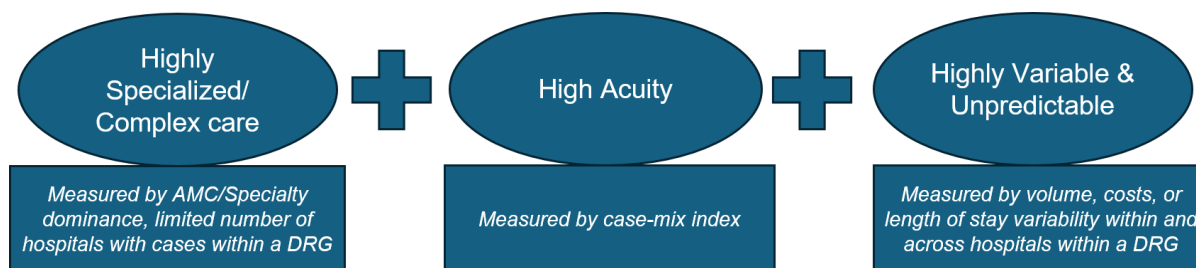
<sup>7</sup> Due to the desire to align with CMMI this policy uses MS-DRGs and not APR-DRGs, that are used in most HSCRC policies. All references to DRGs should be assumed to reference MS-DRGs

was preferable. While staff believe that using DRGs erodes procedure specificity, for purposes of alignment, simplification and transparency, staff have pivoted to an MS-DRG based approach for defining eligible carve-out services.

### Establishing a Definition of Highly specialized care for carve-out consideration

Highly specialized and complex care refers to advanced tertiary and quaternary services for rare or life-threatening conditions delivered at the highest levels of care, for this purpose, Staff have defined that specifically as tertiary and quaternary care at AMCs<sup>8</sup> and tertiary care at Maryland Institute for Emergency Medical Services Systems (MIEMSS) and National Cancer Institute (NCI)-designated specialty centers.<sup>9</sup>

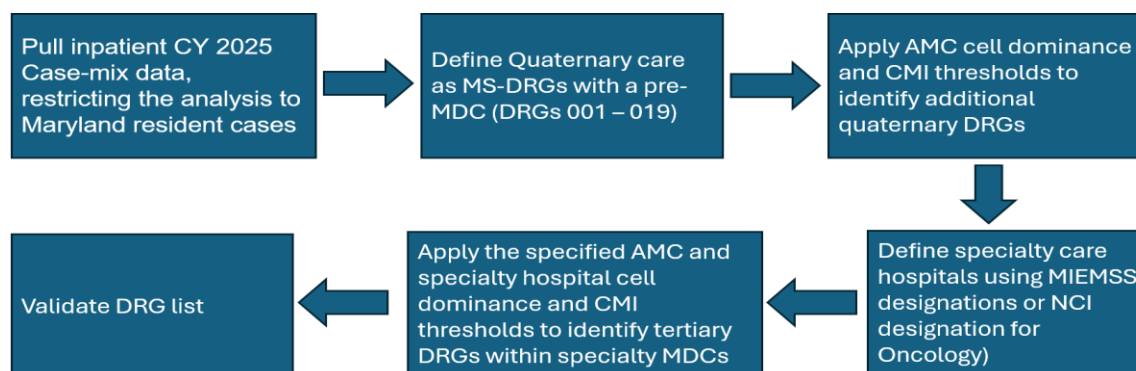
Cases considered for carve-out under this policy must meet all three of the following criteria:



It is important to note that high acuity does not necessarily always equate to highly specialized care. Highly acute and specialized care includes services often delivered at a limited number of specialty designated hospitals such as burn care, NICU and Trauma services. These services will be eligible for carveouts. On the other hand, highly acute but not specialized care includes cases with a high CMI but for which services have greater volume dispersion, such as cardiac services. While cardiac services are also highly acute there are 24 cardiac centers in the state and volumes are broadly distributed across all hospitals, indicating that they are relatively accessible rather than highly specialized. As such some of these services are less obviously suitable for carve-outs. Services prioritized for the carve-out should also be unpredictable or inconsistent in terms of cost, volume, length of stay, or care pathway. These types of cases are not ideal for a population-based methodology due to their variable nature and therefore would be identified as carve-out eligible.

Staff developed a formulaic approach, which is described in Figure 3, to identify potential carveouts and modeled two scenarios. Appendix 6 of this draft recommendation outlines the methodology in detail.

**Figure 3. Formulaic DRG-Based Approach to Identify Highly Specialized Care<sup>10</sup>**



<sup>8</sup> A limited number of hospitals with advanced resources for treating highly complex cases

<sup>9</sup> A limited number of hospitals with specialized programs and resources for treating highly complex cases within a given specialty such as trauma, NICU, cardiac specialty designations

<sup>10</sup> Process relies on DRG and Major Diagnostic Categories (MDC) for analysis.

### Scenario 1 - More restrictive

Included all “pre-MDC” categories (DRGs 1-19), quaternary and tertiary services at AMCs with a cell dominance of 50 percent and CMI of 2.5, Burn cases at a 90 percent cell dominance threshold and 1.5 CMI, Trauma at 50 percent cell dominance and a 2.5 CMI and NICU cases with a 60 percent cell dominance and 1.5 CMI. The pre-MDC DRGs were included because, by definition, they represent a set of highly specialized services. For the remaining categories thresholds were set based on the observed distribution of cases in that category in order to balance inclusion of high acuity services with the relative level of dispersion in that service area. In this model only the Burn, Neonatal Intensive Care Unit (NICU) and Trauma specialties were included as they are the only categories with MIEMSS designation which represent services delivered by only a few select hospitals. Using FY 2025 case-mix data this scenario rendered 48 DRGs amounting to 1.4 billion in total charges, the equivalent of 6.8 percent of in-state revenue of which 63% was delivered at AMCs (See Figure 4).

**Figure 4. More Restrictive Scenario Results**

Total carve out charges		% of In-state revenue*		Number of DRGs			
\$ 1.4B		6.8%		48			
% AMC Contribution to Carve out charges		% Specialty Hosp Contribution to Carve out charges		% Other Hosp Contribution to Carve out charges			
63%		17%		20%			

Categories	Quaternary		Tertiary					
	Pre-MDC (DRGs 1-19)	AMC Dominance	Cardiac	Stroke	Burn	Trauma	NICU	Oncology
Cell Dominance	-	50%	-	90%	90%	50%	60%	-
CMI	-	2.5	-	1.5	1.5	2.5	1.5	-
Charges in \$M	\$654.5	\$190.2	-	-	\$15.4	\$ 331.1	\$240.5	-

### Scenario 2 - Less Restrictive with Clinical Edits

Realizing that there are some areas of highly specialized care are not captured by the more restrictive scenario, staff revised scenario 1 to incorporate cardiology cases at 90 percent cell dominance and 2.5 CMI and oncology cases at 60 percent cell dominance with 1.5 CMI. Using FY 2025 case-mix data, this scenario renders an additional 18 DRGs bringing the total DRGs eligible for carve-outs to 78. This scenario expands and provides more comprehensive coverage of specialized clinical areas statewide while still prioritizing services performed at AMCs resulting in only a slight decrease in concentration when compared to scenario 1. Therefore, Staff used the list generated by Scenario 2 as a starting point for further clinical review and refinement.

Initial clinical evaluations flagged DRGs related to cardiac valves for removal from the carve-out lists given the high level of dispersion across hospitals. However, hospital stakeholders have argued for their re-statement given that high clinical acuity and specialization. Staff have re-instated the DRGs related to cardiac valves identified by the methodology to the carve-out list but will monitor on an annual basis as potential advances in technology and dispersion could warrant removal in the future.

Spinal fusion DRGs, cardiac defibrillator DRGs, AICD and certain cardiac device implant DRGs that made the list based on the methodology were later determined based on clinical review as not carve-out eligible. These DRGs were deemed as “standard of care” and not highly specialized given the level of dispersion across hospitals despite their high levels of acuity.<sup>11</sup> These DRGs were subsequently manually removed from the staff proposed carve-out list, reducing the list to 66 DRGs. These 66 DRGs that constitute the proposed carve-out list are shown in Appendix 2.

Statewide, cases attributed to these 66 DRGs equal about \$1.9 billion in total charges, equivalent to 9.4 percent of total in-state revenue. This list prioritizes highly specialized care performed at AMCs (58 percent of total charges), tertiary services performed at specialty hospitals (28 percent of total charges) and tertiary services at other community hospitals (14 percent of total charges) (See Figure 5)

Staff remains open to further assessments and discussion on specific DRGs, especially NICU DRGs, tracheostomy DRGs and a handful of DRGs that meet the trauma inclusion criteria but might not reflect highly specialized care due to relatively wide dispersion. NICU also presents a challenge due to the relatively crude categorization available in MD-DRGs.<sup>12</sup>

**Figure 5. Less Restrictive Scenario Results with Clinical Edits**

Total carve out charges		% of In-state revenue*		Number of DRGs	
\$ 1.9B		9.4%		66	
% AMC Contribution to Carve out charges		% Specialty Hosp Contribution to Carve out charges		% Other Hosp Contribution to Carve out charges	
58%		28%		14%	

Categories	Quaternary		Tertiary					
	Pre-MDC (DRGs 1-19)	AMC Dominance	Cardiac	Stroke	Burn	Trauma	NICU	Oncology
Cell Dominance	-	50%	90%	90%	90%	50%	60%	60%
CMI	-	2.5	2.5	1.5	1.5	2.5	1.5	1.5
Charges in \$M	\$654.5	\$96.5	\$568.1	-	\$15.4	\$319.3	\$240.5	\$66.5

The staff methodology did not include specific specialty designations for other service lines such as orthopedics or neurology, as Maryland does not issue standalone specialty hospital licenses for those services. Hospitals specialty status for these programs is typically designated through hospital accreditation, clinical ratings and the presence of a state-sanctioned Trauma Center. The staff methodology includes MIEMSS designated Trauma Centers which captures DRGs that are highly specialized pertaining to these service lines.

## Funding and Implementation

Staff recommend that all in-state cases with DRG assignments on the DRG Carve-out list, regardless of whether they are seen at an AMC, specialty or community hospital, be removed from all eligible volume

<sup>11</sup> See Appendix 4: DRGs that Made Carve-out List but were Removed Upon Clinical Review

<sup>12</sup> See Appendix 5: DRGs on Carve-outs List but are flagged for Further Investigation

methodologies and instead be funded at a 100 percent variable cost factor (VCF) to prevent any duplicate funding.<sup>13</sup> As such, hospitals will be held 100 percent liable for changing volumes associated with these cases. Funding for all other cases, not eligible for carve-outs, will maintain the respective inpatient medical and surgical service line VCFs. The Carve-out Policy will replace the current Complexity and Innovation Policy therefore, any prospective adjustments relevant to that policy will be reversed once the carve-out policy is approved and in effect; retrospective adjustments for FY 2025 and 2026 will be made. Staff will continue to include carve-out eligible volumes in the various quality pay for performance programs and the PAU Redistribution Policy.

Effective July 1, 2026, the Commission will begin using the Carve-out service DRG list to remove from Maryland FY 2027 Global Budgets all cases with DRGs identified on the list. Hospital baselines will be set using Calendar Year (CY) 2025 performance inflated to FY 2027. However, due to the volatile nature of highly specialized and complex services, hospitals with small volumes will have their baseline assessed using a three-year average. At such a time when CMMI has a final carve-out list, staff will seek to align its list with the CMMI list no later than January 1, 2028. Staff have reviewed a preliminary list from CMMI and believe Maryland is aligned generally, although the specific list will still require reconciliation.

## Additional Considerations

### Hospital-level data

Staff are working to quantify the magnitude of volumes eligible for carve-outs at the hospital-specific level. Staff are aware that volumes eligible for carve-out will vary across hospital types, so it is important to set base line volumes at the hospital specific level that are appropriate and reflect true hospital activity. Year over year hospital performance will be measured against the baseline to determine hospital carve-out growth or decline. For hospitals with significantly low volumes in the CY 2025 base year, Staff recommends using a blended CY 2023 – CY 2025 average to establish the base. The threshold for volumes deemed as “significantly low” will be determined by the amount of hospital-specific volume dispersion from the statewide average. Staff plans to distribute hospital-specific carve-out volume details to hospitals shortly after the release of this draft recommendation.

### Outpatient Cosmetic Surgery Exemption

HSCRC has long permitted hospitals, who meet the requirements of the program, to provide discounts below approved rates for some cosmetic surgeries. For the most recently reported four quarters statewide charges under this program were \$1.3 million or approximately 0.01% of statewide regulated revenue across 5 hospitals (payments were significantly less since discounts are provided). In response to stakeholder advocacy and to allow greater flexibility, Staff recommend revenues charged in compliance with this program also be carved out of the global budget. Given the minimal revenue involved, no global budget adjustments will be made for this carve out, however, staff agree that these revenues will no longer impact year end GBR compliance.

### Monitoring and Updating of Carved Out Services

The list proposed in this recommendation will be used for carve-outs in FY 2027 and may be modified for future periods as follows:

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<sup>13</sup> Volume methodologies including but not limited to Market Shift Adjustment, Demographic Adjustment, Surge Funding, Deregulation, and Repatriation/Expatriation

1. **CMMI List:** Staff will work with CMMI on the carve out list under their Hospital Global Budgets and where possible update the Maryland list to match the final CMMI list in CY 2028.
2. **Adding DRGs:** Staff will annually review DRG updates to consider if new DRGs should be added to the carve out list
3. **Removing DRGs:** Staff will annually review utilization of DRGs on the carve-out lists and consider removing DRGs which have diffused across a majority of hospitals and that may no longer qualify as specialized. At the time the changes are made, charges will be added back to the global budget for dropped DRGs based on recent utilization levels. Such adjustment will only be made once diffusion is believed to be complete to avoid locking into the global budget utilization patterns that do not reflect the end state of diffusion.
4. **Program Monitoring:** Staff will monitor utilization across carved out DRGs to ensure there are not unintended consequences opposed to the goals of the carve out, the HSCRCs regulatory mandate or the AHEAD model and make changes should unintended consequences be noted.
5. **AHEAD Carve-out Limit:** Staff will monitor overall utilization to ensure compliance with the carve-out limit under the AHEAD model and consider changes to ensure the most appropriate use of the carve out should the State be close to the 15 percent cap.

Any changes contemplated under the bullets above will be shared with the relevant HSCRC workgroups. Material changes under any of these provisions will be subject to Commission approval.

## Recommendations

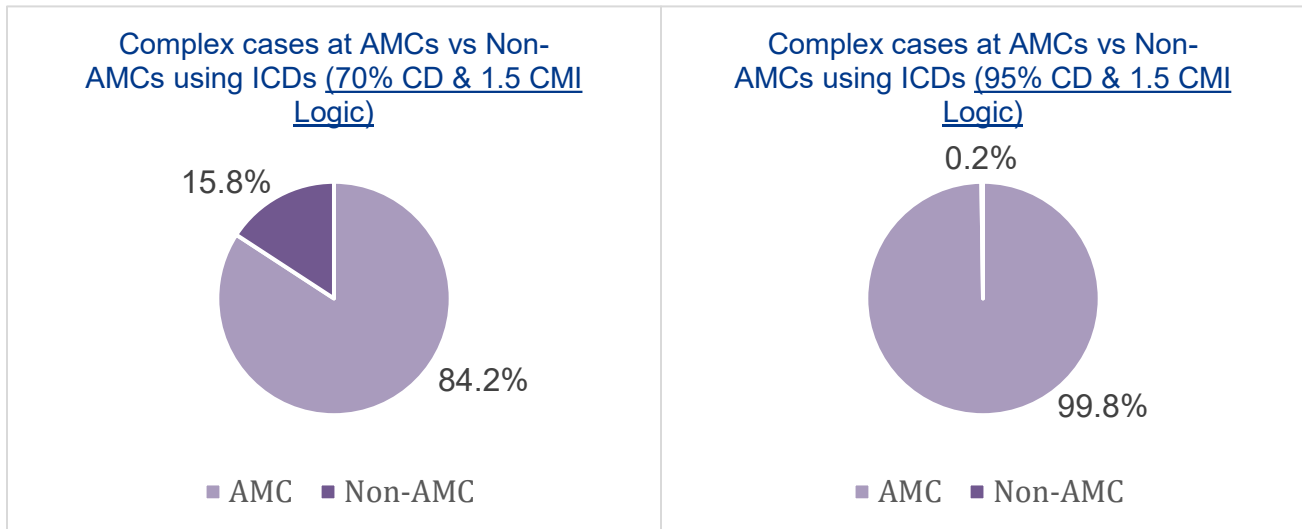
Based upon the analyses and validations performed by staff, staff is proposing the following recommendations

1. Staff propose the adoption of the less restrictive list effective July 1, 2026, which carves out approximately 9.4 percent of statewide revenue associated with highly specialized care from population-based methodologies
  - Proposed carve-out list prioritizes highly specialized tertiary and quaternary care performed at AMCs (58 percent), with expansions to include certain tertiary services also performed at non-AMCs (41 percent)
  - The list could be updated effective January 1, 2028, based on desired alignment with a final CMMI list
2. Staff propose the use of CY 2025 charges, inflated to FY 2027, as the baseline for carve-out eligible volume which would be removed from global budgets. The baseline for lower volume hospitals should be based on a three-year average
3. Staff propose that all volumes eligible for carve-outs under this policy are funded at 100 percent variable costs and hospitals are held 100 percent liable for volatility
4. All prospective adjustments in FY 2027 rates relevant to the current Complexity and Innovation Policy will be reversed upon a Carve-out Policy approval, retrospective adjustments for FY 2025 and FY 2026 will be made
5. Staff propose the removal of all carve-out cases from all other volume methodologies including the Market Shift, Demographic Adjustment, Surge Funding, Deregulation, and Repatriation/Expatriation.

- a. Continue including carve-out eligible cases in the quality pay-for-performance and PAU Redistribution assessments
6. Staff propose to review the list annually (1) for potential additions and subtractions and (2) to understand the impact of the policy. Material changes will be brought to the Commission for approval
7. Volumes eligible under the existing Outpatient Cosmetic Surgery program will also be carved out effective July 1, 2027

## Appendices

## Appendix 1: Complex Cases at AMC versus Non-AMCs Using High End and Low-End Procedure-Based Dominance Thresholds



## Appendix 2: Staff Proposed DRG Carve-outs List

HSCRC Proposed Carveouts list	
MSDRG	Description
1	Heart Transplant or Implant of Heart Assist System with MCC
2	Heart Transplant or Implant of Heart Assist System without MCC
3	ECMO or Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. Procedures
4	Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck without Major O.R. Procedures
5	Liver Transplant with MCC or Intestinal Transplant
6	Liver Transplant without MCC
7	Lung Transplant
8	Simultaneous Pancreas and Kidney Transplant
10	Pancreas Transplant
11	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy with MCC
12	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy with CC
13	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy without CC/MCC
14	Allogeneic Bone Marrow Transplant
16	Autologous Bone Marrow Transplant with CC/MCC
17	Autologous Bone Marrow Transplant without CC/MCC
18	Chimeric Antigen Receptor (CAR) T-Cell and Other Immunotherapies
19	Simultaneous Pancreas and Kidney Transplant with Hemodialysis
20	Intracranial Vascular Procedures with Principal Diagnosis Hemorrhage with MCC
23	Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator
25	Craniotomy and Endovascular Intracranial Procedures with MCC
28	Spinal Procedures with MCC
29	Spinal Procedures with CC or Spinal Neurostimulators
31	Ventricular Shunt Procedures with MCC
140	Major Head and Neck Procedures with MCC
143	Other Ear, Nose, Mouth and Throat O.R. Procedures with MCC
212	Concomitant Aortic and Mitral Valve Procedures
215	Other Heart Assist System Implant
216	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC
217	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with CC
218	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization without CC/MCC
219	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with MCC

220	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with CC
221	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization without CC/MCC
228	Other Cardiothoracic Procedures with MCC
231	Coronary Bypass with PTCA with MCC
232	Coronary Bypass with PTCA without MCC
233	Coronary Bypass with Cardiac Catheterization or Open Ablation with MCC
234	Coronary Bypass with Cardiac Catheterization or Open Ablation without MCC
235	Coronary Bypass without Cardiac Catheterization with MCC
236	Coronary Bypass without Cardiac Catheterization without MCC
266	Endovascular Cardiac Valve Replacement and Supplement Procedures with MCC
267	Endovascular Cardiac Valve Replacement and Supplement Procedures without MCC
268	Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC
270	Other Major Cardiovascular Procedures with MCC
319	Other Endovascular Cardiac Valve Procedures with MCC
405	Pancreas, Liver and Shunt Procedures with MCC
492	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with MCC
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC
650	Kidney Transplant with Hemodialysis with MCC
651	Kidney Transplant with Hemodialysis without MCC
652	Kidney Transplant
653	Major Bladder Procedures with MCC
789	Neonates, Died or Transferred to Another Acute Care Facility
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate
829	Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other Procedures with CC/MCC
834	Acute Leukemia with MCC
837	Chemotherapy with Acute Leukemia as Secondary Diagnosis or with High Dose Chemotherapy Agent with MCC
838	Chemotherapy with Acute Leukemia as Secondary Diagnosis with CC or High Dose Chemotherapy Agent
846	Chemotherapy without Acute Leukemia as Secondary Diagnosis with MCC
927	Extensive Burns or Full Thickness Burns with MV >96 Hours with Skin Graft
928	Full Thickness Burn with Skin Graft or Inhalation Injury with CC/MCC
929	Full Thickness Burn with Skin Graft or Inhalation Injury without CC/MCC
955	Craniotomy for Multiple Significant Trauma
956	Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma
957	Other O.R. Procedures for Multiple Significant Trauma with MCC
958	Other O.R. Procedures for Multiple Significant Trauma with CC

### Appendix 3: Specialty Hospital Designations

HOSPID	Hospital Name	Cardiac	Stroke	NICU	Burns	Trauma
210029	Bayview Medical Center (JHM)	Y	Y	Y	Y	Y
210003	Capital Region Medical Center (UM)	Y		Y		Y
210012	Sinai Hospital of Baltimore (LifeBridge)	Y	Y	Y		Y
210022	Suburban Hospital (JHM)	Y	Y			Y
210001	Meritus Medical Center	Y				Y
210019	Peninsula Regional Medical Center (TidalHealth)	Y				Y
210027	Western Maryland (UPMC)	Y				Y
210024	Union Memorial Hospital (MedStar)	Y				
210023	Anne Arundel Medical Center (Luminis)	Y		Y		
210005	Frederick Health Hospital	Y		Y		
210044	Greater Baltimore Medical Center			Y		
210004	Holy Cross Hospital - Silver Spring	Y		Y		
210048	Howard County Medical Center (JHM)	Y		Y		
210008	Mercy Medical Center			Y		
210011	Saint Agnes Health (Ascension)	Y		Y		
210063	Saint Joseph Medical Center (UM)	Y		Y		
210057	Shady Grove Medical Center (Adventist HealthCare)	Y	Y	Y		
210015	Franklin Square Medical Center (MedStar)	Y	Y	Y		
210043	Baltimore Washington Medical Center (UM)	Y				
210033	Carroll Hospital (LifeBridge)	Y				
210037	Shore Medical Center at Easton (UM)	Y				
210062	Southern Maryland Medical Center (MedStar)	Y				
210049	Upper Chesapeake Medical Center (UM)	Y				
210016	White Oak Medical Center (Adventist HealthCare)	Y				

*Note: Stroke only looked considered Thrombectomy and Comprehensive stroke centers*

#### Appendix 4: DRGs that Made Carve-out List but were Removed Upon Clinical Review

<b>MS-DRG</b>	<b>Description</b>
226	Cardiac Defibrillator Implant without Cardiac Catheterization with MCC
227	Cardiac Defibrillator Implant without Cardiac Catheterization without MCC
245	AICD Generator Procedures
258	Cardiac Pacemaker Device Replacement with MCC
275	Cardiac Defibrillator Implant with Cardiac Catheterization and MCC
276	Cardiac Defibrillator Implant with MCC or Carotid Sinus Neurostimulator
277	Cardiac Defibrillator Implant without MCC
456	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with MCC
457	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with CC
458	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions without CC/MCC
459	Spinal Fusion Except Cervical with MCC
471	Cervical Spinal Fusion with MCC

## Appendix 5: DRGs on Carve-outs List but are flagged for Further Investigation

MS-DRG	Description
4	Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck without Major O.R. Procedures
492	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with MCC
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC
653	Major Bladder Procedures with MCC
789	Neonates, Died or Transferred to Another Acute Care Facility
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate

## Appendix 6: Methodology

Using FY 2025 Case-mix data, staff methodology to quantify highly specialized care eligible for carve-outs include a 5-step process

1. Define Quaternary care as MS-DRGs with a pre-Major Diagnostic Category (MDC) (DRGs 1 – 19)

Pre-MDC DRGs are specialized procedure-driven hospital cases that are categorized strictly by high-cost, high-resource surgical procedures regardless of the principal diagnosis, such as organ transplants or tracheostomies. The pre-MDC category typically includes DRGs 001 through 019 and because they require the highest level of specialization, are typically handled by major academic medical centers.

2. Apply AMC cell dominance and CMI thresholds to identify additional quaternary DRGs

After scoring DRGs 1-19 as quaternary, staff further quantifies quaternary services at AMCs by isolating cases where AMC volumes combined make up the larger share of statewide activity, greater than 50 percent of statewide volumes, and with a case-mix index of 2.5 or greater.

3. Define specialty care using Maryland Institute for Emergency Management Services Systems (MIEMSS) designations (National Cancer Institute (NCI) designation for Oncology)

To define tertiary services eligible for carve-outs, staff used MIEMSS trauma and specialty center designations to identify Maryland hospitals that are officially verified and equipped to handle specific, life-threatening medical emergencies. The MIEMSS specialty and referral center designations used in the staff approach include adult and pediatric trauma centers, comprehensive stroke and thrombectomy centers only, cardiac interventional centers, adult and pediatric burn centers and Level III and IV perinatal and neonatal intensive care units.<sup>14</sup><sup>15</sup> Staff used NCI designations to identify tertiary oncology services.<sup>16</sup>

4. Apply AMC and specialty hospital cell dominance and CMI thresholds to identify tertiary DRGs within specialty MDCs

After defining tertiary hospitals, staff determined specialty DRGs by way of MDCs assigned to the specific service. Staff quantified tertiary services at AMCs and specialty hospitals by isolating cases where AMC and specialty volumes combined made up a larger share of statewide activity within the MDC's DRG listing. Recognizing that DRG distributions and associated costs and technology vary within services, staff varied the cell dominance and CMI thresholds for the various specialty services.<sup>17</sup>

5. Validate DRG list

The final step involved performing various validations to further refine the staff list. These include:

- a) **Threshold calibration:** Staff recognized that the cell dominance and CMI thresholds will need to vary across specialty services based on DRG volume distributions and level of specialty service dispersion. For example, in Maryland, cardiology has 24 specialty designated hospitals while oncology only has two. Also, DRGs assigned to the cardiology

<sup>14</sup> Maryland Institute for Emergency Medical Services Systems (MIEMSS) <https://www.miemss.org/home/hospitals/specialty-referral-centers>

<sup>15</sup> See appendix 3: Specialty Hospital Designations

<sup>16</sup> National Cancer Institute (NCI) <https://www.cancer.gov/research/infrastructure/cancer-centers/find>

<sup>17</sup> See Figure 6: Less Restrictive scenario results with Clinical edits. For the various cell dominance and CMI thresholds per specialty

MDC in FY 2025 make up about 58,000 statewide volumes while oncology equates to about 3,700.

- b) **Severity hierarchy validations:** Staff reviewed “With Complication or Comorbidity” DRGs (CC) and “With Major Complication or Comorbidity” (MCC) DRG hierarchies to ensure consistent application within DRG families. When a CC DRG met the carve-out thresholds for highly specialized and complex services while the corresponding MCC DRG did not, the corresponding MCC variants were manually included in the carve-out list to maintain alignment across the DRG family. However, in instances where the MCC made the carve-out list while the CC did not, no change was made. We assume in such an instance that the methodology appropriately isolates the more highly specialized and acute service for carve-out. This is a change from the previous approach to remove from the list DRG families in instances where a lesser complication DRG made the list while a more complicated one did not.
- c) **Exclusion review:** Staff also reviewed and excluded from its list, few select medical DRGs pertaining to rehabilitation and psychiatry that met the various cell dominance and CMI threshold criteria to classify as highly specialized care.
- d) **Clinical Validation:** Staff had the list of identified DRGs reviewed by clinical experts who found the Staff approach to be directionally sound and analytically rigorous. Various DRGs were flagged for removal from the carve-out lists, while a few others were flagged for further review.<sup>18</sup>
- e) **Year over Year validation:** Staff performed longitudinal analyses to validate consistency of the DRG list over time. The majority of DRGs identified as highly specialized remained relatively consistent between FY 2023 and FY 2025 with fewer than 10 DRGs newly classified as highly specialized under the same criteria.
- f) **Comparisons to other stakeholder developed carve-out lists:** The staff list was compared against other stakeholder-developed lists including Sg2 and another developed by a hospital system to which there was significant overlap. The staff list also includes NICU DRGs which the other lists do not include.

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<sup>18</sup> See Appendix 4 and 5

The next HSCRC Public Meeting is **Wednesday, July 22, 2026.**

*The meeting originally scheduled for July 8 has been rescheduled to Wednesday, July 22, 2026.*